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PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

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AP Photo/Alex Brandon

Mike Campbell, from Aurora, Colo., shows his ticket from the Century Aurora 16 Theater for a showing of the Batman movie "The Dark Knight Rises." Campbell was in the theater on July 20 when 12 people were killed and more than 50 wounded in a shooting attack during the movie. See article below.

Aurora CMHC Immediately Puts Crisis Plan Into Action

Twelve people are killed and many more wounded at a Batman movie, reawakening memories of similar past tragedies and future need for care.

BY AARON LEVIN

The gunman who killed 12 moviegoers and wounded 58 others at a midnight showing of a Batman movie in Aurora, Colo., on July 20 wrote yet another chapter in the history of American violence.

The next morning, the Aurora Community Mental Health Center activated its crisis plan and by 1 p.m. opened a 24-hour walk-in clinic for anyone affected by the tragedy.

That included people who had been in the theater, their friends and families, hospital staff, emergency personnel, and civilian volunteers who had transported some of the injured to the hospital. The center also sent a pair of five-person crisis teams to local high schools.

"The quick response at the center and in the community gives us some sense of control," said the center director, psychiatrist Leslie Winter, M.D., in an interview 10 days after the shootings and shortly after pulling the night shift in the center's walk-in clinic. "People know there's a place to go and that help and support are available."

The 18 full- and part-time staff psychiatrists have been taking overnight shifts, doing therapy support work, and taking walk-in cases, she said. The added burden on local mental health services is expected to last at least a year or more.

"We don't limit our services to people directly affected by the shooting," said Winter. "There is a lot of secondary trauma with people listening to the news or having memories of Columbine triggered off."

The 1999 Columbine High School massacre in another Denver suburb left 15

*see **Colorado Shooting** on page 25*

Expert Panel Calls Dearth of Clinicians To Treat Elderly 'Emerging Crisis'

An expert panel says the number and training of geriatric mental health and substance use specialists are inadequate.

BY AARON LEVIN

Baby boomers aren't babies anymore.

As more of them pass their 65th birthdays, both the absolute numbers of older people and the proportion with mental health and substance use problems will rise, reported the Institute of Medicine (IOM) in July.

There were 40.3 million people in the United States aged 65 and older in 2010, a figure that will jump to 72.1 million by 2030, according to the U.S. Census Bureau.

Yet despite the scale and inevitability of this onrushing demographic wave, too few psychiatrists and other mental health professionals stand ready to care for its members.

"We're now at the edge of an emerging crisis," said Dan Blazer, M.D., a professor of psychiatry and behavioral sciences at Duke University and chair of the IOM panel that produced the report. "The burden of illness among older persons is significant, and the pressures on primary care, nursing homes, and direct care will increase."

That insight has been visible on the horizon for at least a decade.

A paper published in 1999 by Dilip Jeste, M.D., now president of

*see **Elderly** on page 24*

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

THERE ARE GOOD REASONS AMERICAN PROFESSIONAL AGENCY IS A LEADER IN PROVIDING MALPRACTICE INSURANCE FOR PSYCHIATRISTS

HERE ARE TWO OF THEM.

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FROM THE PRESIDENT

International Members Benefit APA, And Vice Versa

BY DILIP JESTE, M.D.

As Kofi Annan, former secretary-general of the United Nations, said eloquently, "Arguing against globalization is like arguing against the laws of gravity." The world is more interconnected today than ever before. APA, whose primary focus is to be the voice of American mental health care, has also become much more internationally oriented during recent decades. In this column I will discuss the topic of expanding APA's international activities—one of my priorities during the coming year. The goal is to increase APA's international membership, as well as enhance our collaboration with international organizations on issues of clinical care, training, research, and public education critical to our field worldwide.

Historically, the first international psychiatrists joined APA in 1936 as corresponding members. Later, this designation was changed to international members. As summarized by Mel Sabshin, the late medical director of APA, in his outstanding memoir, *Changing American Psychiatry: A Personal Perspective,* the leadership of American psychiatry prior to World War II was mostly home grown, with a few noteworthy exceptions such as Weir Mitchell and Adolph Meyer. With the postwar immigration of many Austrian, German, and Central European psychiatrists to the United States, psychoanalysis became a central focus of American psychiatry; these expatriates transformed the practice of psychiatry in their adopted land.

Over the next several generations, American psychiatry became increasingly global, and it also has influenced international psychiatry. An obvious example is the worldwide adoption of *DSM-III* and *DSM-IV.* On another front, APA's Committee on International Abuse of Psychiatry and Psychiatrists and its Committee on Human Rights were involved in ethical and human-rights issues around the world, notably in the erstwhile U.S.S.R., Chile, South Africa during the era of apartheid, and Cuba. The APA Board of Trustees has frequently spoken out against human-rights abuses pertaining to psychiatry globally.

Just as American psychiatry has contributed to the field of mental health internationally, we too have benefitted in a major way from the work of our colleagues in other countries. Approximately 15 percent of the members of the *DSM-5* work groups are psychiatrists from outside of North America. The *American Journal of Psychiatry* and *Psychiatric Services* not only have gained increasing readership in different countries, but they also are receiving and publishing high-quality papers written by international researchers. The United States has imported treatments from other parts of the world, such as tai chi, meditation, and yoga, which are no longer considered alternative treatments but rather part of integrated health care. APA has been working with international organizations to promote cooperation. An example of this is the collaboration with the World Health Organization to help harmonize *DSM-5* and *ICD-11.* We also are joining efforts with the World Psychiatric Association to distribute educational resources in countries where they are not easily accessible.

APA has more than 1,600 international members from more than 90 countries. These include 194 members from the Netherlands, 119 from Brazil, and 109 from India. There is a growing interest in joining APA among psychiatrists worldwide. A survey conducted during APA's 2011 annual meeting among nonmember international attendees showed that many of them would like to be part of APA. International members especially value educational opportunities that APA provides, such as conferences and training, as well as access to journals and other informational vehicles. At the same time, our international colleagues have been a great resource of new ideas and intellectual capital. In addition to sharing best practices, they often serve as mentors for deciphering cultural nuances. A more interconnected world means more opportunities to work across borders. As psychiatrists, we all cherish our commitment to generate and disseminate knowledge, support psychiatric training, and provide outreach for people in need, no matter where they live.

I encourage international psychiatrists to consider joining APA and help us continue our efforts to enhance international connections and foster excellence in psychiatry across the globe. APA membership provides unique opportunities for career growth through education, networking, and collaboration.

see ***From the President*** *on page 7*

PSYCHIATRIC NEWS

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APA NEWS

Register Now For APA's Fall Meeting

Stuart Monk/Shutterstock

APA's next major meeting—the Institute on Psychiatric Services—is being held October 4 to 7 in New York City. It is often referred to as APA's "little gem" because of its high quality and smaller size than the annual meeting; it also offers intimate settings that promote interaction with faculty. This year's theme is "Pursuing Wellness Through Recovery and Integration."

Advance registration is now open at *www.psychiatry.org/learn/institute-on-psychiatric-services*. Register before **September 14** and save on fees. For more information, see page 16.

Departments

PROFESSIONAL NEWS

GID Report Stresses Need For Psychiatrist Involvement

With subjective improvement as the primary outcome, the existing evidence base combined with clinical consensus is sufficient for developing recommendations for an APA practice guideline on treatment of adults with gender identity disorder.

BY MARK MORAN

Current literature is adequate for APA to develop consensus-based treatment recommendations for patients—including children and adolescents—with gender identity disorder (GID) and associated disorders, including disorders of sexual development.

And for adults, the research base is sufficient for the development of a formal APA practice guideline, with gaps in the research database filled in by clinical consensus.

Those are the principal findings of the Task Force on Treatment of Gender Identity Disorder, which was appointed by the APA Board of Trustees in 2008. A report from the task force appears as a data supplement to the August *American Journal of Psychiatry.*

Task Force Chair William Byne, M.D., noted that treatment recommendations focusing on a process of stepwise transitioning for individuals wishing to change their gender were originally published in 1979 by the Harry Benjamin International Gender Dysphoria Association (now the World Professional Association for Transgender Health—WPATH). More recently the Endocrine Society has developed an evidence-based guideline for cross-sex hormone administration and also for pubertal suspension in adolescents.

But Byne told *Psychiatric News* that APA-developed treatment recommendations can speak to the unique role that psychiatrists can play in the comprehensive treatment of people with GID.

"The purpose of psychiatric guidelines would be to complement, not to replace or compete with, the WPATH," Byne told *Psychiatric News*. "The practice of various mental health professions overlaps considerably, but the practice of psychiatry is unique in many respects, particularly when it comes to assessment and pharmacological management of serious mental illness such as major depressive disorder, bipolar disorder, and psychotic disorders. A psychiatric guideline would address the assessment and treatment of GID in the context of such disorders. Also, their medical training puts psychiatrists in a unique position to liaison with other medical professionals who provide care to these individuals. A psychiatric guideline would provide guidance in those uniquely psychiatric aspects of care where guidance is currently lacking."

The task force addressed GID and related issues in four populations, three of which are defined by age: children, adolescents, and adults. The fourth population comprises individuals with the desire to change their assigned gender who have a somatic disorder of sex development (DSD). The latter refers to congenital conditions—formerly referred to as intersex disorders, hermaphroditism, and pseudohermaphroditism—which entail atypical development of chromosomal, gonadal, and/or genital sex.

(For a summary of findings with regard to children and adolescents, see related story below.)

In all four populations, the research literature was evaluated by assessing the existence of eight levels of evidence (listed from the highest quality of evidence to the lowest): randomized, double-blind clinical trials; randomized nonblinded clinical trials; nonrandomized, nonblinded clinical trials; cohort

see ***GID*** *on page 23*

Key Points

The research literature is adequate for APA to develop consensus-based treatment recommendations for patients—including children and adolescents—with gender identity disorder (GID) and associated disorders, including disorders of sexual development (DSD).

- For treatment of adults, an APA task force called for development of a formal evidence-based practice guideline.
- Existing literature is insufficient to support development of an APA practice guideline for treatment of GID in adolescence, but is sufficient for consensus recommendations. Especially important is the emergence of evidence that pubertal suspension is an intervention that results in a high degree of patient satisfaction.
- In the case of DSD (sometimes referred to as intersex disorders), the management of gender assignment at birth has implications for the development of later gender dysphoria, and the patient could benefit from the involvement of a psychiatrist or other mental health professional.

Bottom line: Psychiatrists have a unique role in the comprehensive treatment of individuals with gender-variant behavior or gender identity disorder, and treatment recommendations based on existing clinical consensus may be helpful.

Consensus Begins to Gel Regarding Treatment of Youth With GID

Among very young children who express gender variant behavior, some will grow up to be transgender, but a much larger proportion will not.

BY MARK MORAN

Despite a dearth of literature on treatment of gender identity disorder in children and adolescents—as well as a wide range of opinions and some degree of controversy—recommendations from APA based on several areas of consensus can be helpful to clinicians.

That was the finding of the Task Force on Treatment of Gender Identity Disorder whose report appears in the August *American Journal of Psychiatry.*

For children under 12, the task force found no randomized or adequately controlled nonrandomized longitudinal studies and very few follow-up studies without a control group either with or without an intervention. The majority of available evidence is derived from qualitative reviews and experimental systematic single-case studies that do not fit into the APA evidence grading system, the task force stated in its report.

Despite these deficiencies, areas the task force found that support development of consensus recommendations include the following:

- Assessment and accurate *DSM* diagnosis of the child referred for gender concerns, including the use of validated questionnaires and other validated assessment instruments to assess gender identity, gender role behavior, and gender dysphoria.
- Diagnosis of possibly coexisting psychiatric conditions.
- Identification of mental health concerns in the caregivers and difficulties in their relationship with the child.
- Provision of adequate psychoeducation and counseling to caregivers.
- Provision of age-appropriate information to the child.
- Assessment of the safety of the family, school, and community environments in terms of bullying and stigmatization related to gender atypicality and addressing suitable protective measures.

Task force member Edgardo Menvielle, M.D., noted that gender dysphoria in very young children is especially complex. "We know that young kids who express gender dysphoria or gender-variant behavior are not necessarily transgender," he told *Psychiatric News.* "There is a subset of those children who will grow up to be transgender, but also a larger proportion who will not. That is one of the clinical quandaries that a child psychiatrist must face because we do not have the tools to predict the adult outcome of gender dysphoria in young children."

A similar lack of studies was found with regard to adolescents. Database searches failed to reveal any randomized, controlled trials, with the quality of the evidence primarily limited to individual case reports, follow-up studies with control groups of limited utility and without random assignment, and longitudinal follow-up studies after an intervention without control groups.

But consensus recommendations for treatment of adolescents might

see ***Consensus*** *on page 24*

PROFESSIONAL NEWS

Military, VA Can Do Better In PTSD Response, Experts Say

The Institute of Medicine again examines the status of treatment for posttraumatic stress disorder for troops and veterans—and offers suggestions for improving diagnosis and care coordination.

BY AARON LEVIN

The departments of Defense and Veterans Affairs have made strides in identifying and caring for troops and veterans with posttraumatic stress disorder (PTSD), but must continue efforts to improve coordination of care, standardize diagnosis and treatment, and gather better data on outcomes, according to a new report from the Institute of Medicine (IOM).

"If we can work collectively to improve those areas, we can get to where the leaders of the VA and DoD want to be, where all soldiers with PTSD get the care they need and return to full functioning," said the IOM panel chair, Sandro Galea, M.D., Dr.P.H., a professor and chair of the Department of Epidemiology at the Mailman School of Public Health at Columbia University.

The report is based on two years of analysis of information available from published sources, interviews, and hearings. A second phase of the same panel's inquiry will review data from ongoing treatment trials and other studies forthcoming from the departments of Defense (DoD) and Veterans Affairs (VA). Those results will be reported in 2014.

More than 2.6 million military personnel have served in Afghanistan since 2001 and in Iraq from 2003 to 2011, said the report. Data indicate that between 13 percent and 20 percent have or may develop PTSD.

In one sense, there was little that was "new" or "groundbreaking" about PTSD in the IOM's report, but it was useful, nonetheless, said Galea in an interview.

"It is not surprising that we found a lack of coordination of care for our soldiers, or a host of barriers to care, or that programs are implemented in idiosyncratic ways," he said. "But looking at all the information systematically and drawing conclusions in one place focuses our collective minds on what needs to be done."

Both departments have taken strides to identify service members or veterans with PTSD, the IOM report pointed out. "[T]his progress needs to be followed by timely access to the best evidence-based care."

The IOM panel called on the DoD and VA to "evaluate the efficacy, effectiveness, and implementation of all their PTSD screening, treatment, and rehabilitation services. . . . " A number of prevention programs now in use in the various services were considered as well.

The two departments collaborated on a set of guidelines published in 2010, which now form the basis of their approach to PTSD.

The VA screens its patients for PTSD at least annually during primary care visits, and the IOM panel suggested that military treatment facilities and TRICARE (the DoD's contractor for medical care) should do the same. They also advised that both departments continue investigating the use of telemental health and other technologies to overcome barriers to care.

The IOM urged the two departments to explore the value of complementary and alternative medicine interventions, from yoga and acupuncture to animal-assisted therapy, especially given their acceptability by patients, despite a small evidence base for their efficacy.

Both agencies must dig deeper, however, the IOM panel said.

"The DoD and the VA should [also] support neurobiology research that might help translate current knowledge of the neurobiology of PTSD to screening, diagnosis, and treatment approaches and might increase the understanding of the biologic basis of evidence-based therapies," the panel suggested.

"The report affirms what we do and points out areas for further attention and research," said Antonette Zeiss, Ph.D., chief consultant for the Office of Mental Health Services at the VA's headquarters in Washington, D.C., in an interview with *Psychiatric News*.

The VA has said that it will hire 1,600 mental health professionals and 300 support staff to meet the expanding need for services, said Zeiss.

"And we are trying to address internal obstacles like fear of stigma by integrating PTSD care into our primary care clinics," she said. "We are especially trying to engage vets who don't engage with traditional specialty mental health services."

At DoD, the Army has been rolling out RESPECT-Mil, a program that screens for PTSD and depression at every visit in primary care settings.

The report also expressed the panel's concern that while clinicians were trained to provide accepted therapies, there was little knowledge about how closely they actually adhered to the protocols.

The VA can track fidelity very well in training, said Zeiss. How to do so while covering millions of patients in day-to-day practice is another matter.

"We are developing templates to work with our electronic health records to record use of evidence-based psychotherapies and track the therapeutic alliance and how well the patient is doing session by session," she said.

Overall, the IOM panel sought to encourage both departments even as they pointed out certain shortcomings.

"I'm optimistic," said Galea. "I hope this report is one of a series of small drops in the bucket of change." PN

VA Boosts Psychiatrists' Salaries To Remedy Workforce Shortage

Ratcheting up the top pay grade for psychiatrists may help the Veterans Health Administration recruit more clinicians around the United States.

BY AARON LEVIN

The Veterans Health Administration wants to hire more than a few good psychiatrists and is willing to pay more than a few dollars extra to get them.

Psychiatrists say they'd like to work (or continue working) for the VHA but existing salary levels were proving an obstacle, said a statement from the Department of Veterans Affairs.

At least one very practical obstacle stands in the way of luring more psychiatrists. "Starting salaries for VA psychiatrists . . . are far below the starting salaries offered by private health care, state mental health programs, and even Department of Defense programs," said James H. Scully Jr., M.D., CEO and medical director of APA, in an April letter to the Senate Committee on Veterans' Affairs.

In some cases, the Department of Defense has offered at least a $50,000 boost in annual salary to VHA psychiatrists to jump ship, according to a May memorandum from Michael Culpepper, acting chief officer of the Department of Veterans Affairs' Workforce Management and Consultant Office.

The current salary range at the VA for Tier 1 psychiatrists is $97,987 to $195,000. Existing pay flexibility apparently has not led to recruiting and retaining enough psychiatrists. The top of the new range will rise to $250,000 and become the new permanent standard, according to a VA spokesperson.

The VHA currently has about 2,500 psychiatrists on its staff and had about 400 openings in mid-July, not counting the positions to be filled under the most recent authorization. Those new positions began being posted on May 16.

The VA said it will especially target recruitment for rural areas and will develop more psychiatric residency and loan-forgiveness programs. The department has expanded its mental health professions trainee program at the VA's rural health facilities since 2007 with a 42 percent increase in psychiatry resident positions, a 61 percent increase in psychology trainee positions, and a 26 percent increase in social worker trainee positions.

To manage existing vacancies, VA facilities are now allowed to use existing staff, contract staff, locum tenens, or consultant psychiatrists or psychologists. Other prescribers, like nurse practitioners or physician assistants, may also be used to provide psychiatric coverage. Telemental health services from sites with extra capacity may be used to cover sites with limited capacity. PN

AAPDP to Meet in Italy

The American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) is holding its 14th Joint Meeting with the Organizzazione di Psicoanalisti Italiani Federazione e Registro in Florence on October 20 and 21. The theme of the conference is "Multicultural Factors in Psychotherapy." Carlotta Miles, M.D., a prominent psychiatrist and psychoanalyst and expert on the topic, will be the keynote speaker.

The AAPDP is an APA allied organization, founded more than 50 years ago, the largest national and international organization for psychodynamic psychiatrists and medical psychoanalysts. The organization works at the interface of psychiatry, psychoanalysis, neuroscience, and the social sciences.

APA members are invited to attend this international meeting. A registration form and hotel information are posted at the academy's Web site at *www.aapdp.org*. More information is available by sending an e-mail to *info@aapdp.org* or calling (888) 691-8281. PN

Mikhail Malyshev/Shutterstock

Distortions Plague Portrayals Of Schizophrenia on Film

While campaigns to educate the public about mental illness and those who suffer from it have made progress, misinformation and stereotypes about people with schizophrenia remain common in movies.

BY CHRISTOPHER WHITE

Movies and television shows can be a major source of information for the public about mental illness, but accuracy has often been absent from many of these depictions.

Because of media portrayals, schizophrenia in particular has long been stigmatized, due in part to the general ignorance that a substantial part of the public still has about the illness and its symptoms. Movie characters, such as the "homicidal maniac" who has schizophrenia, are examples of the stereotypes on which Hollywood continues to rely.

Patricia Owen, Ph.D., a professor and chair of the Department of Psychology at St. Mary's University in San Antonio, Texas, and her colleagues sought to understand how schizophrenia was being portrayed in contemporary movies. They viewed 72 movies produced from 1990 to 2010, and identified 41 movies and 42 characters that they determined met *DSM-IV-TR* criteria for a diagnosis of schizophrenia or that displayed unusual behavior due to schizophrenia.

They found that these movies supported, but also sometimes refuted, stereotypes and misconceptions about the illness. Their study showed that 83 percent of the characters who were depicted as having schizophrenia displayed violent behaviors, with 69 percent engaging in self-harm that ranged from self-mutilation to suicide, and almost one-third of these characters displayed homicidal behavior. Violent behavior was the major stereotype researchers found characters playing into.

"The 'homicidal maniac' is one stereotype that has persisted throughout cinematic history, beginning with D.W. Griffiths' 1909 classic, 'The Maniac Cook,' " said Glen Gabbard M.D., coauthor of *Psychiatry and the Cinema*, in an interview with *Psychiatric News*. "The proportion of homicidal patients with severe mental illness who kill in the movies is grossly exaggerated compared to instances of homicide by the severely mentally ill in real life. However, filmmakers view themselves as owing no debt to reality—only to their audiences, who come to the cineplex with specific expectations." Gabbard is a clinical professor of psychiatry at Baylor College of Medicine in Houston and a professor of psychiatry at SUNY Upstate Medical Center in Syracuse, N.Y.

Owen and her colleagues found that about 25 percent of the film characters who were depicted as having schizophrenia killed themselves, which misrepresented the actual suicide rate for such individuals in the United States, estimated to be between 10 percent and 16 percent. Other symptoms commonly depicted included auditory or visual hallucinations and disorganized thoughts or speech. Seven characters (17 percent) with schizophrenia displayed special talents in areas such as mathematics, science, or music, and five (12 percent) were portrayed as having paranormal abilities such as being able to communicate with "otherworldly and often malevolent forces."

Owen and her colleagues analyzed the characters' demographic characteristics, symptoms and stereotypes, causation, and treatment, if any.

Of the analyzed characters, 79 percent were male, and 95 percent were Caucasian. Demographically, the results showed that 45 percent were shown as being of low socioeconomic status, which is consistent with epidemiological data on people with schizophrenia, and 25 percent were of high socioeconomic status. About three-fourths of the films did not attempt to explain causation for the illness, although almost one-fourth implied that experiencing a traumatic event was the reason for a character's schizophrenia.

Psychotropic medication was used as treatment for over half of the characters portrayed as having schizophrenia, and the myth of love curing the illness was prevalent in almost a quarter of the movies. Group therapy and psychotherapy were used as treatment for only a small number of characters.

"This study appears to be the first to provide an empirically based content analysis of the portrayal of schizophrenia in contemporary movies," said the researchers. "[The results] will help clarify the prevalence and nature of stereotypes and misinformation found in this widely patronized entertainment medium."

They also acknowledged a need for further research on ways to correct stereotypes. They added, "Future efforts extending this line of research would contribute to the discourse on the optimal uses of entertainment media to correct misinformation about schizophrenia and to promote an informed understanding of those with schizophrenia and other mental illnesses." PN

An abstract of the report can be found at *http://ps.psychiatryonline.org/article.aspx?articleID=1148545*.

From the President

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Among the many benefits of APA international membership are registration discounts to APA's annual meeting and the Institute on Psychiatric Services; free online subscriptions to the *American Journal of Psychiatry* and *Psychiatric News*; discounts at the annual meeting on more than 700 titles (including *DSM*) in 29 languages from American Psychiatric Publishing; discounted continuing medical education programs, including practice-guideline courses; and access to the APA Online International Referral Directory. We also work extensively on increasing the presence, visibility, and recognition of our international members at annual meetings and through other forums. There are other plans such as a column on international activities in *Psychiatric News*. There are three categories of international membership—member, fellow, and distinguished fellow. Our international membership fees are scaled according to the World Bank Gross National Income categories: $50 for low-income countries, $125 for lower-middle-income, $175 for upper-middle-income, and $205 for high-income countries. Please visit the APA Web site at *www.psychiatry.org/join-participate/international-psychiatrists* for more details. The APA Board of Trustees, at its most recent meeting, approved a one-time 25 percent discount for all new international members. I invite you to send us your suggestions regarding APA's international activities.

To conclude, I echo what Mel Sabshin wrote: "Whether it is recognized or not, all psychiatrists are internationalists, and the field of psychiatry is international." PN

Annual Meeting Photos Now Online

Did *Psychiatric News* snap a photo of you at APA's 2012 annual meeting? Take a moment to browse through the collection and find out. Photos can be accessed at *www.printroom.com/ViewGallery.asp?userid=dhathcox&gallery_id=3081592*. Photos are available for purchase.

LEGAL NEWS

Short, Temporary Detentions Make Commitment More Likely

States are urged to aim for a temporary detention order period of 72 hours to allow a complete clinical evaluation after a patient's mental health crisis.

BY CHRISTOPHER WHITE

Research has shown that temporary detention orders (TDOs) that are 48 hours or shorter are sometimes inadequate to evaluate patients fully after they have suffered a mental health crisis. This can lead to involuntary hospital commitments that can increase stigma and trauma.

Tanya Wanchek, Ph.D., J.D., with the Weldon Cooper Center for Public Service, and Richard Bonnie, LL.B., an attorney with the School of Law, both professors at the University of Virginia, looked at the length of TDOs and correlated that information with the percentage of mental health commitments and dismissals.

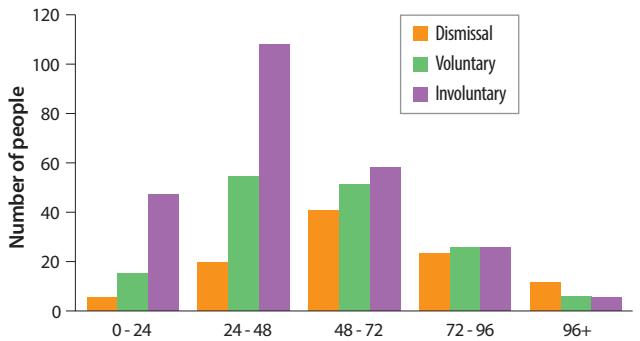
The researchers expected a correlation between longer TDO length and an increase in dismissals. Because states have different TDO periods, they used Virginia as an example of states with shorter TDO periods: while most states require a commitment hearing within four to eight days, and three states allow up to 30, Virginia is one of the few states that has a four-hour detention period. However, this period can be extended to up to five days because of weekends and holidays.

Researchers gathered data on Medicaid hospitalization claims and compared those data with the Virginia Supreme Court's Court Management Systems to track commitment hearing outcomes in 2008. The data set (n=500) included 356 white individuals (71 percent), 130 black individuals (26 percent), and 14 individuals (3 percent) of other ethnicities. Sixty-two percent of the subjects were female; 31 percent were diagnosed with a schizophrenia disorder, and 46 percent were diagnosed with affective psychosis.

The study results showed that shorter TDO periods (less than 48 hours) had a direct relationship to higher numbers of involuntary commitments, while longer TDO periods had a direct relationship related to higher numbers of dismissals and voluntary commitments.

Length of Temporary Detention Orders Correlated With Outcomes

The graph shows the relationship between the length of temporary detention orders (TDOs) and outcomes for patients suffering a mental health crisis. The data came from the Virginia Supreme Court's Court Management Systems and Medicaid recipients. Data show that involuntary hospitalizations are related to shorter TDO length.



Source: Tanya Manchek, Ph.D., J.D., et al., *Psychiatric Services,* June 2012

"The benefits of longer TDO length are that it allows evaluators more time to conduct a thorough evaluation, provides an opportunity to individuals in crisis to stabilize, and increases the likelihood that the subsequent hospitalizations will be voluntary," Wanchek told *Psychiatric News.* "These benefits have prompted the Virginia Tech Review Committee, the Office of Inspector General, and the Commission on Mental Health Law Reform to recommend longer TDO periods [in Virginia legislation]."

Researchers cited the investigation of the Virginia Tech shooter in 2007 as a reason to extend the detention period. The inspector general for mental health, mental retardation, and substance abuse services said the short period from detention to the commitment hearing "makes it very difficult, if not impossible, to collect and consider additional collateral information about the individual. This also makes it difficult to complete the physical exam and psychiatric evaluation, assessment, and treatment plan before the commitment hearing is held."

Wanchek and her colleagues also noted some limitations of the report. Bias about the individual's health can influence the length of the TDO and hospitalization; for example, researchers mentioned that clinicians sometimes fast-track patients into involuntary commitment because they are familiar with the patient.

However, clinicians may not have control over TDO hearings either. For example, an informal study performed by Virginia's Commission on the Mental Health Law Reform found that some jurisdictions schedule TDO hearings every other day; therefore, when an individual is detained, his or her hearing will take place on the next scheduled hearing day rather than being scheduled by the clinician. This could mean that the patient's health is not the primary factor in determining TDO length.

The researchers noted that even though this study identifies the relationship between TDO periods and results of commitment hearings and hospitalizations, more research is needed to determine the costs of increased TDO periods. PN

An abstract of "Use of Longer Periods of Temporary Detention to Reduce Mental Health Civil Commitments" is posted at *http://ps.psychiatryonline.org/article.aspx?articleid=1151384.*

Drastic Reform Urged for Solitary Confinement

Prisoners have the right to avoid punishment such as solitary confinement that can produce harmful psychological effects or exacerbate psychiatric conditions, APA tells Congress.

BY JONATHAN WOLFE

The mental health effects associated with prolonged solitary confinement demand close consideration and should influence any future policy on use of the practice in U.S. prisons.

So asserted APA Medical Director James H. Scully Jr., M.D., in testimony submitted in June in advance of a congressional hearing on the human-rights, fiscal, and public-safety consequences of solitary confinement.

Held before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, the hearing featured testimony from federal and state law enforcement officials, academics, and advocates, including Craig Haney, Ph.D., J.D., a professor of psychology at the University of California, Santa Cruz, and Anthony Graves, an exonerated former death-row inmate who spent the majority of his 18 years at a Texas prison in solitary confinement.

"I lived under the rules of a system that is literally driving men out of their minds," said Graves in describing the inhumane conditions of serving time in a small cell without access to human interaction or proper medical care. "No one can begin to imagine the psychological effects isolation has on another human being."

According to recent estimates from the Web-based advocacy project Solitary Watch, approximately 82,000 inmates are currently segregated in federal and state prison systems in the United States. And a 2010 study published by the American Academy of Psychiatry and the Law (AAPL) concluded that segregation over prolonged periods of time has the capacity to induce harmful psychological effects such as anxiety, anger, cognitive disturbance, perceptual distortion, obsessive thoughts, paranoia, and psychosis.

> "I lived under the rules of a system that is literally driving men out of their minds."

The AAPL study also estimated that between 8 percent and 19 percent of current U.S. prisoners suffer from psychiatric disorders, with an additional 15 percent to 20 percent of prisoners requiring some form of psychiatric intervention during incarceration. These individuals, according to AAPL's findings, often require costly psychiatric hospitalization or crisis-intervention services, and face a heightened risk of suicide.

see ***Solitary Confinement*** *on page 24*

MEMBERS IN THE NEWS

'Most Traveled Psychiatrist' Completes Epic Quest

From the North Pole to Antarctica, from Asia to South America, Dr. Van travels the world and returns to tell the tales of his journeys.

BY AARON LEVIN

Jagannathan Srinivasaraghavan, M.D.

The great Roman arch at Leptis Magna in Libya marks Dr. Van's latest travel adventure and the last of the world's nation-states to be checked off his life list.

Jagannathan Srinivasaraghavan, M.D.

Dr. Van first visited Antarctica in 1985 and made it all the way to the South Pole in 2011 to mark the 100th anniversary of Roald Amundsen's trek to the bottom of the world.

Jagannathan Srinivasaraghavan, M.D., set a personal record when he landed in Libya on February 29. With that country's bloody civil war over, Dr. Van, as he is generally known, visited the last of the 195 officially designated nations on the planet.

"I believe I am the world's most-traveled psychiatrist," said the professor emeritus of psychiatry at Southern Illinois University School of Medicine.

He also ranks 33rd on a list by the Web site Mosttravelledpeople.com, which subdivides the world a bit differently and lists 872 geographic entities (including states and provinces). Van has logged visits to 580 sites on that list.

In Libya, Van saw the bombed-out compound of the late dictator Mu'ammar Gadhafi. Then he visited some much older ruins, the ancient cities of Cyrene and Leptis Magna.

"Leptis was beautiful, a classic Roman city with a great arch at its center," he said.

Getting there brought reminders of up-to-date-reality, though. Traveling outside major cities in Libya required passing through multiple checkpoints, where roadblocks were controlled by young men with AK-47s, he said.

He is no stranger to conflict zones. In 2011, he visited Afghanistan and Iran. Earlier this year, on his way to Libya, he visited South Sudan, a nation created only a year ago but now also embroiled in difficulties with its former parent, Sudan.

Van has been traveling for more than 40 years. When he first arrived in the United States from India in 1970, it was only his seventh country, but he circled the world by 1979, and with a few leaves of absence in the 1980s, reached 100 countries by the early 1990s. He made it to both Antarctica and the North Pole in 1985 and says he was the first Indian citizen to plant the Indian flag on the top of the world.

By 2006, he had logged 140 countries and, after retiring in 2008, pushed the count up to 168.

In December 2011, he went to the South Pole to mark the 100th anniversary of Roald Amundsen's trek.

Van occasionally plays the visiting fireman, dropping in on the local

*see **Quest** on page 25*

RESIDENTS' FORUM

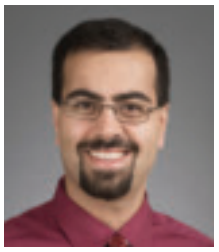
The Changing Face of Psychiatry Training

BY ALIK WIDGE, M.D., PH.D.

You'll see many articles in this paper on changes in psychiatry—a new *DSM,* new treatments, and new laws and regulations. There is a bigger change happening too, a change in how we train psychiatrists and what it will mean to be a psychiatrist during our professional lifetimes.

As the member-in-training trustee on the APA Board, I serve as a liaison to the psychiatry residency directors' association, and I also happen to serve on the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee for psychiatry, giving me an advance view of what's on the horizon.

The role of doctors overall is shifting, and psychiatry is along for the ride. As health systems rely more on allied health professionals (physician assistants, nurse practitioners, and social workers, for example) to deliver routine care, it's no longer enough for a physician to be a skilled clinician.



The expectation is that we will come out of residency prepared to be managers and leaders, trained to direct and coordinate an integrated mental health team. Many of us experience this on inpatient rotations, where we learn to coordinate the actions of nurses, therapists, social workers, and others. Tomorrow's psychiatrists will do that across care settings, and our program directors are trying to figure out how to prepare us for that role.

Within the ACGME, two big projects will support that change. First, starting in 2014, every resident in every specialty will be evaluated against standardized "Milestones"—a set of specific knowledge domains, skills, and behaviors that describe that specialty's expected development trajectory. The psychiatric curriculum won't change much, but that early and frequent feedback will help residents see their skills (and needs) in a new way, and it will help programs train their residents more efficiently. It will also produce a generation of physicians who are much more prepared for the continual monitoring and evaluation that the Maintenance of [Board] Certification process requires.

Second, a set of ACGME initiatives focuses on improving skills in "systems-based practice"—that is, working in a large medical-financial-legal network, allocating resources, and advocating for patients.

These initiatives are driven in large part by resident leaders within the ACGME, based on that vision of physicians as team leaders. Even more initiatives will come as the data accumulate; when the ACGME is receiving individual reports every six months on every resident in the country, and the American Board of Psychiatry and Neurology is getting something similar through its Maintenance of Certification process, we will have unprecedented tracking of psychiatrists across their careers.

Can we as a profession and as individuals use that information to become better clinicians and leaders? Might it be misused by payors or credentialing bodies? Could education researchers find trends that predict patient outcomes?

Furthermore, all of that is happening as the bedrock of residency training, the federal graduate medical education funding that pays our salaries, is under threat. Tracking outcomes through the Milestones will help our institutions make the case for continued funding. Still, if the cuts happen, we may need to rethink psychiatric residency itself. If we can track residents' competency, does everyone need to spend four years in training? For that matter, since the PGY-4 year is mainly electives, should we have it at all? There is no formal proposal on the table, but it has been studied and argued, and it might be again.

These aren't easy questions, and all this change will produce unintended

*see **Residents' Forum** on page 14*

Will Antibiotic Fulfull Its Psychosis-Fighting Promise?

Some of the great medical advances, such as the discovery of nerve growth factor, have involved serendipity. Could the same also apply to the discovery of a potential drug for schizophrenia?

BY JOAN AREHART-TREICHEL

Five years ago, a Japanese psychiatrist and his colleagues observed something peculiar regarding two schizophrenia patients.

One was a 23-year-old man who had been hospitalized for a first episode of schizophrenia. While in the hospital he developed a severe case of pneumonia, which was treated with the antibiotic minocycline. Two weeks later, his schizophrenia symptoms resolved along with his pneumonia.

The other was a 61-year-old man who was diagnosed with schizophrenia at age 20. During his most recent hospitalization for it, he developed a bedsore that was treated with minocycline. Two weeks later, the bedsore healed, and minocycline was discontinued. The patient's schizophrenia symptoms worsened. Minocycline was resumed; within three days, the patient's schizophrenia symptoms improved.

"I was so surprised by these developments," the psychiatrist—Tsuyoshi Miyaoka, M.D., an associate professor of psychiatry at Japan's Shimane University School of Medicine—told *Psychiatric News*. "Could minocycline have antipsychotic properties? I wondered."

Pursuing Their Hunch

Miyaoka and his colleagues decided to explore this possible relationship by conducting a small open-label study. They gave minocycline (150 mg/d) as an adjunct to antipsychotic medication to 22 individuals with schizophrenia for a four-week period. Evaluation of the subjects showed reduction of more than 50 percent in both positive and negative symptoms. These results, even considering a possible placebo effect, suggested that minocycline might possess antipsychotic properties. And what was especially promising was that it seemed to be capable of countering negative symptoms, which are usually intractable.

Deanna Kelly, Pharm.D., director and chief of the Treatment Research Program at the University of Maryland's Maryland Psychiatric Research Center, read about these developments. "I was really excited about them," she said during an interview, and thus she and her colleagues Robert Buchanan, M.D., and Gopal Vyas, D.O., decided to explore minocycline's putative antipsychotic potential.

They gave minocycline to several patients with severe schizophrenia. As Vyas told *Psychiatric News,* he noted changes in these patients that he had never seen before in them. For instance, "Several showed improvement in group attendance and participation. One who exhibited more than a moderate amount of catatonic behavior was far more engaged in his treatment and was able to be successfully discharged after a prolonged hospitalization. He remains in the community to this day."

> "If minocycline has efficacy for negative symptoms, cognitive impairment, or both, that would be terrific and transformative for the field."

About the same time, results from a randomized, double-blind, placebo-controlled trial that had been conducted on minocycline and schizophrenia were published in the February 2010 *Journal of Clinical Psychiatry*. The results, Kelly said, "got us even more fired up about minocycline's potential against schizophrenia."

Yechiel Levkovitz, M.D., of the Shalvata Mental Health Care Center in Hod-Hasharon, Israel, and colleagues had conducted a trial in 54 subjects with early-phase schizophrenia. The subjects had been given an atypical antipsychotic plus minocycline (200 mg/d) or an atypical antipsychotic plus a placebo and were followed for six months.

Minocycline showed a beneficial effect against not just negative symptoms, but against cognitive deficits—deficits that, like negative symptoms, are usually difficult to treat.

Still other minocycline-related schizophrenia results were published in April in the *Journal of Psychopharmacology* by Bill Deakin, M.D., a professor of psychiatry at the University of Manchester in England, and his international team. These results further persuaded Kelly that minocycline possesses anti-schizophrenia properties.

In that study, 144 subjects with early-phase schizophrenia had received antipsychotic treatment as usual plus minocycline or antipsychotic treatment as usual plus a placebo for an eight-week period. Minocycline was found to significantly reduce negative symptoms and somewhat improve positive ones.

But How Might It Work?

So what about this antibiotic is leading to hope that it can be a weapon against schizophrenia, and especially the usually intractable negative symptoms and cognitive deficits of the illness? "We don't really know for sure," Kelly acknowledged. "But minocycline is known to be capable of countering inflammation and of crossing the blood-brain barrier into the brain, and there is also growing evidence that inflammation might play a role in the pathophysiology of schizophrenia. So minocycline might be able to counter schizophrenia by countering inflammation in the brain."

Deanna Kelly, Pharm.D.

Deanna Kelly, Pharm.D., and Gopal Vyas, D.O., discuss their minocycline-schizophrenia trial. "If we can show that this adjunct minocycline treatment works, it could be a breakthrough finding for schizophrenia treatment," Kelly said, "especially since minocycline is inexpensive, we know its long-term safety, and it's already available in the U.S."

Only more research will show whether minocycline is truly an effective medication against schizophrenia, and such research is under way.

Kelly, Buchanan, and Vyas are conducting a randomized, double-blind, placebo-controlled trial, funded by the National Institute of Mental Health, to further explore minocycline's impact on schizophrenia. Fifty subjects with severe schizophrenia who have shown only a partial or no response to the antipsychotic clozapine are being randomized to receive either minocycline (100 mg twice daily) plus clozapine or a placebo plus clozapine for 10 weeks.

"We are looking for its effects on positive and negative symptoms," Kelly said. "We are also studying cognition to see whether minocycline helps with areas such as memory and learning. And we are measuring the levels of inflammatory markers called cytokines in the subjects' blood, since we suspect that minocycline may counter schizophrenia by reducing inflammation in the brain. We hope to have results next spring."

A similar trial is being launched at the University of Texas Health Sciences Center in Houston, Kelly noted.

Also, a $3 million clinical trial of minocycline in schizophrenia patients is getting under way in the United Kingdom, the *Independent* newspaper reported March 2. It is being financed by that country's National Institute for Health Research.

Meanwhile, schizophrenia experts are placing their bets on whether minocycline will turn out to be an effective treatment for schizophrenia.

"Since all [experimental drugs for negative symptoms or cognitive deficits in schizophrenia] have failed to date, you've got to bet that the next one will fail as well," William Carpenter, M.D., director of the Maryland Psychiatric Research Center and chair of the *DSM-5* Psychotic Disorders Work Group, said. "But . . . if minocycline has efficacy for negative symptoms, cognitive impairment, or both, that would be terrific . . . and transformative for the field."

"If minocycline had a clinically significant benefit for negative symptoms and cognitive impairments, then that would be a major scientific and therapeutic breakthrough," Buchanan observed. "I would give it a 50/50 chance [of success], which is quite optimistic for me."

"This is an interesting and off-the-beaten-track approach to augmentation of antipsychotic effects and the targeting of negative symptoms," Peter Buckley, M.D., told *Psychiatric News*. Buckley is dean of the Medical College of Georgia and has conducted schizophrenia research. "There is now a renewed interest in infections and the immunology of schizophrenia," he added. "So this type of drug may have great relevance. Time will tell."

Vyas had this to say: "I am very optimistic that minocycline will provide relief for some of the most debilitating symptoms of schizophrenia."

"From our experience and clinical research, I believe that minocycline will turn out to be a truly revolutionary treatment for schizophrenia," Miyaoka declared. PN

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CLINICAL & RESEARCH NEWS

IED Quite Common, But Treatments Elusive

Boys tend to get angry more than girls do. Yet curiously, intermittent explosive disorder (IED) is equally common among girls and boys.

BY JOAN AREHART-TREICHEL

Ronald Kessler, Ph.D., a professor of health care policy at Harvard Medical School, isn't easily astonished by mental illness. He headed up the National Comorbidity Survey Replication (*Psychiatric News*, July 15, 2005). But the outcome of his most recent national mental disorder prevalence study—of intermittent explosive disorder (IED) among adolescents—came, he told *Psychiatric News*, "as a complete surprise."

"I was surprised by the large proportion of adolescents in the United States who meet criteria for IED," he admitted. "It is one of the most common of all *DSM-IV* disorders among adolescents. . . ."

In essence, Kessler and his team found in their national sample of some 6,500 adolescents in which they used a modified version of the Composite International Diagnostic Interview, that 8 percent met *DSM-IV* criteria for lifetime IED. The disorder is characterized by recurrent episodes of aggression involving violence or destruction of property out of proportion to a provocation or precipitating stressors and is not explained by another mental disorder or by substance abuse.

Still other provocative findings emerged from the study, which was published online in the July *Archives of General Psychiatry.*

IED had an early age of onset, on average at age 12, and was highly persistent, as indicated by 80 percent of lifetime cases meeting 12-month criteria for IED.

Moreover, every other time a youngster with lifetime IED experienced an outburst of anger, he or she injured someone enough that that person needed medical attention.

While more than one-third of adolescents with current IED received treatment for emotional problems in the year before the diagnostic interview, only 7 percent were treated specifically for anger.

And whereas boys were more likely than girls to engage in anger outbursts, the prevalence of IED did not differ between boys and girls. Kessler said he cannot explain this apparent contradiction. But "speculatively," he said, "it's likely that there are a lot of reasons why people have anger attacks. Some of them involve other mental disorders, like conduct disorder, bipolar disorder, and substance use disorder. Others occur for reasons unrelated to mental disorders. And then there are the minority of anger attacks that are due to IED."


Ronald Kessler, Ph.D.

The study results have clinical implications, Kessler believes. "I would like clinicians to know that an awful lot of adolescents have anger attacks who are not being treated," he said. "And if effective treatments exist, there should be efforts to get a higher proportion of these youth into treatment."

Yet when *Psychiatric News* asked Emil Coccaro, M.D., chair of psychiatry at the University of Chicago and an expert on IED treatments, whether there are any evidence-based treatments for IED in adolescents, he replied: "Yes, but there's not that much data in this regard, partly because child and adolescent psychiatrists don't use IED as a diagnosis that often, given that there are other disruptive behavior disorders that they can give as a diagnosis."

David Fassler, M.D., a child and adolescent psychiatrist who is a clinical professor of psychiatry at the University of Vermont and APA's treasurer, noted that "There is no specific or 'approved' treatment for IED. In general, treatment would be individualized to the person.... Psychotherapy will generally be the key, often augmented by medication."

For example, Fassler said, cognitive-behavioral therapy can help youth with the disorder identify situations or behaviors that may trigger an aggressive response and teach them how to manage their anger and control inappropriate responses with relaxation exercises. Medications that may help include antidepressants, anticonvulsants, antianxiety agents, and mood regulators, he said.

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

"Intermittent Explosive Disorder in the National Comorbidity Survey Replication Adolescent Supplement" is posted at *http://archpsyc.jamanetwork.com/article.aspx?articleid=1206777.*

Researchers Pinpoint Biomarker To Detect Brain Injury

Someday, a simple blood test may help field medics or EMTs quantify damage produced by a traumatic brain injury.

BY AARON LEVIN

A quick, accurate, and easy-to-use test to screen for traumatic brain injury (TBI) would be extraordinarily useful on the battlefield and in civilian emergency rooms.

U.S. Army Col. Dallas Hack, M.D., M.P.H., and colleagues think they may be on the right track to find such a biomarker.

"None of the existing approved tests is a truly objective measure of mild brain injury," said Hack, in an interview with *Psychiatric News*. "They all rely on some level of interpretation and clinical information."

By comparison, cardiologists looking for evidence of a heart attack can measure levels of troponin, an enzyme released by damaged heart cells, said J. Marc Simard, M.D., Ph.D., a professor of neurosurgery, pathology, and physiology at the University of Maryland School of Medicine in Baltimore.

"We've been looking for decades for similar biochemical markers to evaluate patients after stroke or TBI, with only disappointing correlations with patient outcomes or severity," Simard told *Psychiatric News.* Simard is not involved with Hack's research.

U.S. forces now use the Military Acute Concussion Evaluation (MACE) to screen for TBI in the field. The test assesses memory, recall, and concentration, and includes basic neurological checks of pupillary response, verbal fluency, and motor coordination. The results of a MACE screening help decide if troops need further evaluation and treatment.

Biomarkers could quantify that status and speed screening, diagnosis, and treatment, said Hack.

Historically, specialists in neurotrauma thought that the blood-brain barrier made it impossible to find anything in the bloodstream that would show evidence of brain damage, he said.

That idea had begun to fade when Hack and researchers from the University of Florida and Walter Reed Army Institute of Research decided on a joint program to look for diagnostic proteins in the blood—in a meeting that took place on the morning of September 11, 2001.

Now, Hack is testing two proteins: ubiquitin carboxyl-terminal esterase L1 (UCHL1) and glial fibrillary acidic protein (GFAP). Both are products released when brain cells are damaged.

UCHL1 is upregulated when neurons are injured, spiking in the blood between one hour and two days after injury, said Simard. GFAP appears about three or four hours and up to four or five days after astrocytes are damaged.

"They are unique enough to brain injury that we know real damage has occurred," said Hack. Phase 1 and 2 trials indicate that the two proteins have a combined increased sensitivity and specificity when measured at the same time.

In collaboration with Banyan Biomarkers of Alachua, Fla., Hack and colleagues are waiting for approval from the Food and Drug Administration to proceed with a large phase 3 clinical trial of 2,000 people (mostly civilians), some with brain injuries, some with other injuries, and a control group with no injuries.

"If successful, this will fundamentally change the approach to brain injury," said Hack.

There may be some caveats, though, said Simard. Damage to the prefrontal cortex may not show up immediately. And while a blood biomarker may have the advantage of simplicity, it will likely be less accurate than tests of cerebrospinal fluid, although the latter are impractical in the field.

A successful clinical trial of UCHL1 and GFAP won't be the end of the line for Hack and his colleagues. Finding other biomarkers to chart treatment and recovery, or manage chronic patients, is the next step.

"What makes a real difference is if we can do something about TBI," he said. PN

Banyan Biomarkers' Web site is *http://banyanbio.com.* Information about MACE is posted at *www-nehc.med.navy.mil/downloads/deployment_health/Web_TBI_clinical_practice_guideline_and_MACE1.pdf.*

Several Strategies Fight Insomnia In Mood-Disorder Patients

BY LYNNE LAMBERG

Sleep medicine experts are enthusiastic about a variation of cognitive-behavioral therapy and advances in light technology as they seek better insomnia treatments.

Adjusting cognitive-behavioral therapy for insomnia (CBTI) to a patient's circadian rhythms may improve both sleep and coexisting psychiatric symptoms.

People with major depressive disorder, anxiety, or bipolar disorder, in particular, often benefit from this approach, according to speakers at the annual meeting of the Associated Professional Sleep Societies in Boston in June.

CBTI aims to replace beliefs and behaviors that undermine sleep with concepts and strategies that promote good sleep, said Rachel Manber, Ph.D., a professor of psychiatry and behavioral sciences at Stanford University School of Medicine.

The benefits of CBTI extend beyond insomnia and include improvements in nonsleep outcomes, such as overall well-being and depressive symptom severity, including suicidal ideation, among patients with baseline elevations, Manber and colleagues reported in the *Journal of Clinical Sleep Medicine* in June 2011.

CBTI practitioners advise a fixed bedtime and rise time for people who have persistent trouble falling and staying asleep, awaken too early, or feel unrefreshed by sleep. Following a regular schedule and restricting time in bed help consolidate sleep.

Some people with depressive disorders, Manber said, have diurnal variations in mood that hinder compliance with the prescribed schedule.

Those who feel better in the evening may delay going to bed. They then may get up too late to get to school or work on time.

Those whose mood is worse in the evening may have trouble postponing sleep until the designated bedtime. They may go to bed early and then awaken earlier than desired.

Those who feel worse in the morning may resist getting out of bed at their designated rise time. Getting up late also pushes circadian rhythms later, further hampering efforts to stick to a fixed bedtime and wake time.

> CBTI aims to replace beliefs and behaviors that undermine sleep with concepts and strategies that promote good sleep.

People with delaying tendencies need ample time to unwind before bedtime, Manber said. Some like to read before going to sleep, but have trouble putting the book down. She suggested that they read only short works at bedtime.

People who awaken too early often experience sleep inertia. Feeling foggy or draggy for an hour or more after awakening may lower their motivation to get going. Advise them to plan ahead, she suggested, to meet a friend in the morning to exercise or have coffee.

Emphasize the importance of getting out of bed at a fixed time, she said, both during treatment and to prevent relapse.

Consider Daily Rhythms in Children Too

Circadian factors may contribute to sleep and behavioral disturbances in children as well as adults, said Kelly Byars, Psy.D., an associate professor of clinical pediatrics at the University of Cincinnati College of Medicine.

Some children require extended rocking, feeding, or soothing to fall asleep. Others stall at bedtime or refuse to go to bed at an appropriate time. Night waking may require prolonged parental intervention.

Few families that come to Byars' clinic have tried delaying bedtime, he said. Parents typically assume it is better to put a child to bed earlier. He and his colleagues find that a "faded bedtime" eases childhood insomnia. They set bedtime to coincide with the child's current sleep-onset time and help parents devise a pleasant bedtime routine.

They encourage parents to monitor crying but not respond to it immediately, aiming to reduce such behavior by not reinforcing it. If parents consistently wait a few minutes before taking a crying child out of bed, Byars said, the child usually falls asleep faster soon. Bedtime then can move earlier.

Some people need multiple alarms staggered temporally as well as spatially to rouse them. A new type of alarm clock jumps off a nightstand and spins, beeping until silenced.

Sergey Ivanov

Getting or avoiding bright-light exposure at specific times may reduce insomnia, according to Leon Lack, Ph.D., a professor of psychology at Flinders University in Adelaide, South Australia. Light traveling through the eyes to the brain sets the body's biological clock.

Evening bright-light exposure can help people who complain that they fall asleep and awaken too early to stay up later and sleep later in the morning, he said, and sleep longer overall.

Exposure to bright light soon after awakening in the morning advances rhythms, helping people with sleep-onset insomnia fall asleep earlier. Avoiding bright light near bedtime helps foster sleep.

Light technology has progressed, Lack said, from stationary light boxes to portable devices such as light visors and eyeglasses equipped with light emitting diodes.

Use of exogenous melatonin also can shift rhythms, said James Wyatt, Ph.D., an associate professor of behavioral sciences at Rush Medical College. Melatonin secretion usually starts about two hours before sleep onset. People with delayed sleep onset who take 0.3 mg melatonin five to seven hours before their usual bedtime may be able to fall asleep earlier. They should anticipate sleepiness, Wyatt said, and avoid driving. He also recommended dimming lights and reducing brightness on television and computer monitors about two hours before bedtime.

People with bipolar disorder often report variability in bedtime and wake times over a single week of nearly three hours, said Allison Harvey, Ph.D., a professor of clinical psychology at the University of California, Berkeley. Sleep loss is highly correlated with daily mood disturbances in this population, she said, and may trigger mania.

Some 47 percent of adults with bipolar disorder in her ongoing study, funded by the National Institute of Mental Health, are unemployed. "It's hard to address sleep issues in people who don't have to get up at a specific time to get to work and may have not have much to look forward to each day," Harvey noted. Many also have comorbid anxiety.

Nonetheless, she said, an eight-week course of CBTI has helped many of the 48 study participants adopt better sleep-management tactics, regularize bedtime and wake time, and improve sleep and mood.

"We hope," she added, "that improved sleep will help prevent recurrences of their bipolar disorder." PN

An abstract of "CBT for Insomnia in Patients with High and Low Depressive Symptom Severity: Adherence and Clinical Outcomes" is posted at *www.aasmnet.org/jcsm/ViewAbstract.aspx?pid=28373*.

CLINICAL & RESEARCH NEWS

Combat Vets With Insomnia Benefit From CBT Variation

Sleep researchers devise novel ways to help military veterans and others overcome persistent insomnia.

BY LYNNE LAMBERG

Brief behavioral treatment can relieve insomnia in combat-exposed military veterans, said Anne Germain, Ph.D., an associate professor of psychiatry at the University of Pittsburgh School of Medicine.

As many as 70 percent of U.S. military veterans who served in Afghanistan or Iraq report having insomnia, she said at the annual meeting of the Associated Professional Sleep Societies in Boston in June.

To help them, she and colleagues adapted and evaluated a two-session cognitive-behavioral treatment for insomnia (CBTI) they had devised for older adults in primary care settings (see page 13).

After being interviewed in person, 40 veterans completed questionnaires, kept sleep diaries, and wore wrist activity monitors to keep track of their schedules for 10 days. They then were randomized to a four-week active or control treatment.

Veterans in the active group met individually with a therapist for about an hour in week 1. They learned why sleeping in bursts or at irregular times as occurs in deployment disturbs sleep and how aligning the body's sleep drive and biological clock promotes restful sleep and optimal alertness.

The therapist prescribed a bedtime and wake time, based on the veterans' sleep diaries. The therapist helped them plan evening activities consistent with the prescribed bedtime and explained how getting up at the same time every day benefits sleep.

Veterans in the control group met individually with a therapist for about 10 minutes in week 1. They were given informational brochures on sleep and insomnia, but no suggestions for behavioral change.

Both groups received short face-to-face booster sessions in week 3, phone calls from the therapist in weeks 2 and 4, and monthly follow-up calls for six months.

Sleep improved in three-quarters of the active-treatment group. To the researchers' surprise, it also improved in half of the information-only group. Those veterans modified behavior on their own. Members of the military are used to following orders, Germain said. They interpreted the informational brochures as directives.

This cost-effective approach may prove sufficient to reduce stress and improve sleep in some military veterans, she said. Research continues to determine whether restoring good sleep also helps prevent mood, anxiety, and addictive disorders in returning veterans.

A single weekend of sleep therapy can jump-start durable relief from chronic insomnia, according to Leon Lack, Ph.D., a professor of psychology at Flinders University in Adelaide, South Australia.

People undergoing intensive sleep retraining (ISR) agree to sleep no more than five hours on a Friday night, inducing mild sleep deprivation. Treatment in the sleep laboratory starts at 10:30 p.m. on Saturday, and continues until 10 p.m. on Sunday. Participants have an opportunity to sleep every 30 minutes—50 opportunities in all. If they fall asleep, they are awakened after three minutes to maintain their sleep-deprived state.

"People who usually don't feel sleep pressure find sleepiness novel and not aversive," Lack said. "Some think they have forgotten how to sleep. In one weekend, we show them they can fall asleep rapidly."

Lack's group recently studied 23 men and 56 women whose insomnia had a mean length of 16 years. They randomly assigned participants to one of four treatment conditions: ISR, stimulus control therapy (SCT—the most widely studied and supported behavioral insomnia treatment) for five weekly sessions, ISR and SCT combined, or, as a control, basic information on how caffeine, alcohol, and other factors affect sleep.

The combined ISR/SCT group had fewer treatment dropouts and more treatment responders. Some 61 percent of these participants reached "good sleeper" status and continued to sleep well at six-month follow-up, Jodie Harris, Ph.D. (also of Flinders University), Lack, and colleagues reported in the January 2012 issue of *Sleep*. PN

More information about research on insomnia in military veterans is posted at *www.veteranssleep.pitt.edu/*. An abstract of "A Randomized Controlled Trial of Intensive Sleep Retraining (ISR): A Brief Conditioning Treatment for Chronic Insomnia" is posted at *www.journalsleep.org/ViewAbstract.aspx?pid=28395*.

Residents' Forum

continued from page 9

consequences.

The one constant is that APA will be there throughout all of it. We have representatives on every committee that's influencing this work, and through writings such as this column, we report back to the community. We take the input you give us and weave it together to develop residency training in the direction our professional needs. (A large part of that is trying to minimize burdens; trainees and attendings alike have been very clear that there is just too much paperwork and bureaucracy in our lives.) As the changes are implemented, we'll build resources to help residents prepare and manage them, just as we've done in creating online modules that will help psychiatrists maintain Board certification.

APA is here for you during your training, but it will also be there for you after, and will continue to be the forum where trainees and trainers can come together to find new solutions. PN

Alik Widge, M.D., Ph.D., is APA's member-in-training trustee and is a PGY-4 resident at the University of Washington.

The Virtual Doctor Will See You Now

Internet-based cognitive-behavioral therapy for insomnia (CBTI) could vastly increase availability of this effective therapy, according to speakers at the annual meeting of the Associated Professional Sleep Societies in Boston in June.

While sleep specialists deem CBTI the treatment of choice for chronic difficulty falling and staying asleep, early awakening, or nonrestorative sleep, its use has been limited by a lack of trained practitioners. An estimated 10 percent to 15 percent of adults report chronic insomnia. Only about 200 clinicians in the United States have been certified in behavioral sleep medicine, however. They usually provide CBTI in six to eight weekly individual or group sessions.

Lee Ritterband, Ph.D., an associate professor of psychiatry and neurobehavioral sciences at the University of Virginia School of Medicine in Charlottesville, demonstrated an online program, Sleep Healthy Using the Internet (SHUTi). It was developed at the University of Virginia with funding from the National Institutes of Health.

A guided six-unit CBTI program, SHUTi uses text, graphics, animations, audio, and video to provide tutorials on sleep management tailored to each user, with feedback, homework, and follow-up.

A study of 28 people with cancer and insomnia found SHUTi use significantly improved sleep, Ritterband and colleagues reported in the July *Psychooncology*.

In a four-year study now in progress, funded by the National Institute of Mental Health and University of Virginia, participants are being asked to use SHUTi for one to two hours a week for nine weeks and to complete daily electronic sleep diaries.

Researchers will compare SHUTi's efficacy with that of a static sleep-education Web site. They have recruited about 150 of the planned 300 subjects.

Colin Espie, Ph.D., a professor of clinical psychology and director of the University of Glasgow Sleep Center in Glasgow, Scotland, described Sleepio, also a six-unit CBTI program.

Sleepio's animated virtual therapist, a cartoon character, "The Prof," addresses each user by name. At the start of each session, The Prof reviews weekly progress based on sleep diary data users enter each morning.

He discusses cognitive, behavioral, and relaxation techniques and personalizes advice with tactics that users select from a menu of options.

Users may interact with other participants or graduates in a forum. Online programs, Espie noted, can offer 24/7 support, provided by the community. "It's exciting," he said, "to see the partnership between therapy and technology."

In a study of 164 adults with chronic insomnia, Espie and colleagues compared Sleepio's CBTI program with a Web-based placebo intervention, also delivered by The Prof, and a waitlist treatment-as-usual control.

CBTI participants fell asleep faster, slept more soundly and longer, and felt better in the daytime. These outcomes are comparable to those of face-to-face therapist-delivered CBTI, the researchers reported in the June *Sleep*.

More information about the SHUTi study is posted at *http://clinicaltrials.gov/ct2/show/NCT01438697*. The SHUTi Web site is *www.shuti.org*. An abstract of "Initial Evaluation of an Internet Intervention to Improve the Sleep of Cancer Survivors With Insomnia" is posted at *www.ncbi.nlm.nih.gov/pubmed/21538678*. An abstract of "A Randomized, Placebo-Controlled Trial of Online Cognitive-Behavioral Therapy for Chronic Insomnia Disorder Delivered Via an Automated Media-Rich Web Application" is posted at *www.journalsleep.org/ViewAbstract.aspx?pid=28534*.

Alzheimer's Data Show Value Of Finding Early Interventions

Researchers and clinicians are looking for new and better ways to understand the aging human brain and to intervene to prevent its decline.

BY AARON LEVIN

"Healthy" and "normal" are relative concepts when thinking about the brain as it ages, said speakers at panel sponsored by the American Association for the Advancement of Science and the Dana Foundation in Washington, D.C., in June.

"All data suggest significant changes in the brain with age," said Marilyn Albert, Ph.D., a professor of neurology and director of the Division of Cognitive Neuroscience in the Department of Neurology at Johns Hopkins School of Medicine and director of its Alzheimer's Disease Research Center.

And "changes" means decline. Regression by a number of measurements happens in normal people, but occurs sooner and on a steeper downward curve among those who later develop dementia, she said.

Studying "optimally healthy" people over time reveals that decline starts in middle age, with steady regression through the 50s, 60s, and 70s, said Albert.

Predictors of decline include levels of physical activity, mental activity, social engagement, and vascular risk factors. Those risk factors include high blood pressure, diabetes, cholesterol, smoking, and weight gain. Those conditions cause small- and large-artery disease, disrupt the blood-brain barrier, and initiate inflammatory and oxidative stress, she pointed out.

Prevalence of Alzheimer's disease is 3 percent among those aged 65 to 74, 19 percent for those aged 75 to 84, and 47 percent for people aged 85 and over, said panelist Richard Hodes, M.D., director of the National Institute on Aging. With the United States' rapidly aging population, that projects to about 14 million people with the disorder by 2050.

Transnational studies indicate that countries with policies that encourage early retirement have greater declines in cognitive function among the elderly, possibly reflecting reduced physical and mental activity, said Hodes.

Looking into the brain's biology, PET imaging shows that amyloid plaques and hyperphosphorylated tau tangles in people with mild cognitive impairment have a five-times greater chance of progressing to Alzheimer's, said Reisa Sperling, M.D., an associate professor of neurology at Harvard Medical School and the director of the Center for Alzheimer Research at Brigham and Women's Hospital.

"And even 32 percent of 'normal' subject have significant amyloid plaque distribution in the frontal cortices," she said.

New research shows that evidence of Alzheimer's disease begins 10 to 20 years before dementia sets in. Discouraging as this might sound, Sperling saw it as good news because it raised the possibility that—someday—there will be a way to detect the disease in its early stages and then intervene to stop, delay, or reverse it.

"We need to move to treating people before irreversible brain loss occurs," she said. If onset were delayed just five years, it would cut Medicare costs for these patients by 50 percent.

Early intervention to prevent, delay, or slow the progression of Alzheimer's would be ideal, especially since 10 phase 3 treatment trials of once-promising medications over the last decade have proved "disappointing." Data from several phase 3 trials are expected to be released this fall, and "even *some* evidence of hitting targets would be good," she noted.

There are some interesting connections between Alzheimer's disease and psychiatric disorders, noted Sperling in an interview with *Psychiatric News*.

For instance, depression has a

see ***Alzheimer's*** *on page 25*

APA MEETINGS

IPS and Community Psychiatry: A Natural Fit

BY HUNTER MCQUISTION, M.D.

The Institute on Psychiatric Services (IPS) has always been APA's venue for ideas, discussion, learning, and networking about community mental health care. So much so that until 1995 it was called the Institute on Hospital and Community Psychiatry. IPS is now identified, too, as APA's forum in which clinical psychiatrists can gather and join in a process in which the newest ideas in psychiatric practice are percolated while also participating in sessions that offer nuts-and-bolts clinical skills enhancement.

Because community psychiatrists have these issues on their minds every day, it's no surprise that our colleagues who strongly identify with community and public-sector work regularly flock to the IPS.

The benefits are manifold. Letting community psychiatrists from across the generational spectrum speak for themselves makes this come alive. When asked, "Why do you attend the IPS?," here's a cross-section of responses:

- **Melinda Randall, M.D.:** After spending the year working hard to help people with mental illness in my community, I look forward to the IPS, where I have found practical, inspiring workshops and lectures. I leave feeling recharged and better equipped to implement evidence-based interventions.

- **Ken Thompson, M.D.:** The IPS is "the" national meeting in American psychiatry focusing on public service. For that reason, this year's meeting in New York City is especially important. Health care reform is happening, and the IPS is the place to learn about it and discuss where and how public-sector psychiatry fits in.

- **Lesha Shah, M.D.:** I'm a PGY-3 at Baystate Medical Center. I first attended the IPS as a medical student and am returning as a resident because of its welcoming environment, clinically oriented presentations, and the exciting sense of potentiality that the programming and attendees foster. I look forward to attending as an APA Public Psychiatry Fellow this year.

- **Linda Gochfeld, M.D.:** It's a smaller meeting with a rich content of interest to community and public-sector psychiatrists. It's a chance to catch up with old friends and colleagues who are doing exciting things.

- **Charles Huffine, M.D.:** The members of the American Association of Community Psychiatrists, who are very involved with this meeting, will assure that the most progressive and current issues are discussed: integrated primary-behavioral health care, recovery in mental health, and many others.

- **Timothy Stone, M.D.:** Compared with the annual meeting, the crowd is smaller, and the sessions tend to be geared more toward the topics that interest me—namely those related to community psychiatry.

- **Paul Rosenfield, M.D.:** For me, the IPS is the most relevant, interesting, and engaging meeting for community psychiatrists. I have been inspired by hearing about the work others are doing, especially related to recovery. I have learned about new strategies to deal with shared challenges, and I have enjoyed meeting up with like-minded colleagues. This conference is small enough to feel comfortable, has outstanding presenters, and stays true to its mission without unnecessary distractions.

- **Sonmolu Shoyinka, M.D.:** IPS is the place to go to get information on the most cutting-edge, innovative thinking in public psychiatry today. If you want to meet the best and brightest minds in the field and to get your thinking stimulated and challenged, don't miss it!

These commentaries by our colleagues speak volumes about the IPS, and this year's institute promises to be a forum where real-life psychiatry of the future will be inspired, debated, and shaped. PN

Hunter McQuistion, M.D., is a member of the IPS Scientific Program Committee and president of the Board of Directors of the American Association of Community Psychiatrists.

FROM THE EXPERTS

Substance Use Disorders in Later Life: A Hidden Epidemic

BY DAN BLAZER, M.D., PH.D.

A wave of baby boomers is entering later life, which will have a major impact upon the delivery of mental health and other medical services to the elderly. All one need consider are the frequent and often contentious debates about the future of Medicare and Medicaid, given the costs to maintain these programs for a doubling of the 65+ age group over the next 30 years.

What is not so apparent is that not only will the absolute numbers of disorders increase given the sheer increase in population, but also the relative importance of some disorders will increase as well. Specifically, middle-aged adults in 2012 are carrying a much higher burden of substance use problems than older adults, and we have no reason to think that this burden among baby boomers will decline significantly as they enter later life. Substance use disorders, frequently an afterthought among psychiatrists treating older adults, will undoubtedly become one of the most important disorders to be addressed in the future.

No one wishes to think of her father, much less her mother, suffering from a substance use disorder. Psychiatrists are not immune to this bias and therefore are reticent to inquire about substance use in their older patients. Yet the numbers suggest that we must screen for these disorders among the elderly if we are to provide adequate care.

In our community-based studies, we found that 23 percent of men in midlife had engaged in binge drinking during the year prior to our survey, and 14 percent of men over 65 reported an episode. The frequencies were much lower for women, but the trend remains. Binge drinking can potentially lead to a host of problems among older adults given that they metabolize alcohol more slowly and are more frail physically. Falls, driving while impaired, and confusion about the use of medications critical to their health are among the concerns. Surprisingly, 4 percent of adults aged 50 to 64 reported using marijuana during the past year.

One of the major concerns emerging from national surveys is that nonprescription use of opioid pain medications approaches 2 percent in persons over age 50. This form of substance use disorder is potentially quite dangerous and has been recognized across the adult population as one of the most critical issues the medical community faces.

The first step in addressing this invisible yet emerging epidemic is proper screening and an estimate of risk given other factors. All older adults should be screened, but some subgroups are at greater risk. Being male, Native American, or Alaska native; being unmarried; and having a lower income and less education, a diagnosis of other psychiatric disorders, and a history of problems with the law and incarceration increase the risk among older adults for experiencing substance use problems.

The CAGE, long used to screen for alcohol use disorders, has been modified to include other substances. For example the key question on a perceived need to reduce use can be modified as follows: "Have you ever felt you should cut down on your drinking or drug use?"

A computerized screening system (the Drug and Alcohol Problem Assessment for Primary Care, or DAPA-PC) has been developed and tested for quickly identifying and addressing substance abuse and related problems in primary care settings, and these can be used by psychiatrists as well. DAPA-PC is a self-administered, Internet-based screening instrument that features automatic scoring, generation of a patient profile for medical reference, and presentation of unique motivational messages and advice for the patient.

Use of a computerized-screening instrument can save clinicians' time by allowing patients to be screened while in the waiting room, resulting in the need for the clinician to follow-up with a patient only when prompted by the results of the screening. In addition, computerized screening may lend itself more to an honest revelation regarding drug use compared with face-to-face discussions. Though older adults are

see ***From the Experts*** *on page 25*

APA NEWS

Membership Issues Prominent On Trustees' Agenda

Want to be a fellow? APA members who have achieved board certification now meet the main eligibility criterion for becoming fellows of the Association.

BY KEN HAUSMAN

The APA Board of Trustees has made it easier than ever to achieve coveted fellowship status, voting at its July meeting to remove the requirement that a psychiatrist must be a general member for five years before becoming eligible to become an APA fellow. The remaining requirement for general members is board certification. Trustees had previously voted to eliminate a requirement that letters of recommendation had to be submitted on an applicant's behalf.

Once APA receives a member's application for fellowship, that member's district branch has an opportunity to offer comments before the application goes to the Membership Committee and the Board of Trustees for final approval.

In addition to enhancing a psychiatrist's professional credentials, fellows can use the FAPA designation on all of their professional documentation and are recognized at the Convocation during the APA annual meeting. Fellows also receive a lapel pin and a certificate indicating their status.

Fellowship applications are available on APA's Web site at *www.psychiatry.org/join-participate/member-benefits/becoming-a-fellow.* Applications can be filled out online or faxed to (703) 907-1085 and must be received at APA by September 1.

The Board also voted at the July meeting to fund the APA Diversity Leadership Fellowship from the American Psychiatric Foundation's reserves, if the foundation's board approves, to replace the annual $165,000 grant formerly provided by pharmaceutical manufacturer AstraZeneca. The fellowship, which was funded by the company for 15 years, is a vehicle for getting residents involved in the work of APA through participation in the annual meeting and committees, councils, and other components and preparing them for future leadership roles.

In other actions, the Board voted to

- change the **national dues rates** on almost every category of membership primarily to reflect a new graduated dues structure for early career psychiatrists. In some cases dues will decline, with first-year general-member dues for U.S. members dropping the most—by $130. The largest increase will be in sixth-year dues for U.S. general members—$180. The increase for members in their seventh year of membership and beyond—the category that affects the greatest number of APA members—will be $10. Member-in-training dues will decline by $30 for U.S. residents. Dues for APA fellows will rise by either $5 or $10.

Canadian members, who pay lower dues than their U.S. counterparts in each membership category, will also see their annual dues adjusted either up or down.

The new dues structure does not affect district branch/state association dues, which are set by those entities.

- support a proposal from the Membership Committee to offer a one-time 25 percent discount on first-year dues to all **new international members**. This is an addition to the multiple strategies that the Board and other APA leaders have implemented as part of their commitment to boost the Association's international membership.

- endorse two action papers from the Assembly on issues pertinent to the **mental health of transgender and gender-variant individuals**. One paper relates to access to medical care and its impact on the mental health of these individuals, advocating for removal of barriers to care and support for public and private insurance coverage for gender-transition treatment. The other paper on this topic concerns the pervasive discrimination transgender individuals face. It puts APA on record supporting laws that protect their civil rights and explains the mental health consequences of discrimination and lack of equal rights in areas such as health care, employment, housing, and licensing. PN

The 2013 APA national dues rates can be accessed at *www.psychiatry.org/join-participate/becoming-a-member.* A summary of actions from the Board of Trustees' July meeting will be posted on the APA Web site at *www.psych.org/home/access-denied?returnUrl=/network/board-of-trustees/governance-meetings.*

APA Provides Online Resources on State Health Exchanges

If you have questions or need more information about the state health insurance exchanges established by the Affordable Care Act, turn to APA. The Association has posted information on its Web site at *http://psychiatry.org/statehealthexchanges* on the new state health exchanges, essential health benefits, mental health parity, and other related topics.

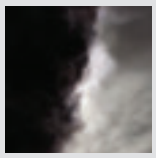
Psychiatric Services Gets Top Ranking

With the release of the latest impact factors in June, *Psychiatric Services* has regained its position as the top-ranking mental health journal in the Health Policy and Services category. Of the 62 journals ranked by impact factor in this category, *Psychiatric Services* ranks 9. No other mental health journal ranks higher. Impact factors for peer-reviewed journals are calculated annually by Thomson Reuters as part of *Journal Citation Reports.*

APA Opposes Dangerous Drug Quantities From PBMs

APA is opposed to pharmacy benefit managers' filling prescriptions for 90 days' worth of certain medications due to concerns from clinicians about dispensing high volumes of medication to potentially suicidal patients. APA's position and recommendation on pharmacy benefit management (PBM) companies' policies that incentivize provision of high quantities of medications can be read at *www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2012_PBMpolicies.pdf.*

Get Latest Advice on Treating Patients After Traumatic Event

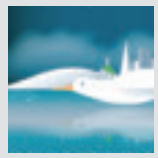


To assist members of the health care community who may be treating a patient affected by the shootings in Aurora, Colo., or another tragic event, American Psychiatric Publishing is offering a free compilation of chapters from the recently published book *Disaster Psychiatry: Readiness, Evaluation, and Treatment* by Frederick J. Stoddard Jr., M.D., Anand Pandya, M.D., and Craig L. Katz, M.D. The chapters can be accessed at *www.appi.org/Pages/TreatingPatientsintheWakeofaTraumaticEvent.aspx.*

Start Preparing for CPT Code Changes

Almost all of the codes in the psychiatry section of CPT (the 908xx series of codes) will be changing in January 2013. While APA is not permitted to provide specific information about the new CPT codes that will be used for psychiatry services until they are published by the AMA this fall, there are a number of actions a practice can take to prepare for the code changes. That information is posted at *www.psychiatry.org/practice/managing-a-practice/coding--reimbursement/changes-to-psychiatry-cpt-codes.* Also, look for more information in coming issues of *Psychiatric News.*

Submit Your Abstract for The 2013 Annual Meeting



APA is now accepting abstracts for the 2013 annual meeting in San Francisco. You can submit a symposium, workshop, or scientific and clinical report. The deadline for submissions is Thursday, September 13. More information is posted at *http://ww4.aievolution.com/apa1301/.*

Behavioral Health IT Bill Benefits Psychiatric Facilities

The Behavioral Health Information Technology Act of 2012 (HR 6042) has been reintroduced by Rep. Tim Murphy (R-Pa.), a practicing psychologist and cochair of the Congressional Mental Health Caucus, to address an omission in the first bill. The American Recovery and Reinvestment Act of 2009 (ARRA) contained Medicare and Medicaid incentives for individual psychiatrists and most hospitals to adopt electronic medical records (EMRs), but some facilities were left out—among them, public and private psychiatric hospitals, community mental health centers, and addiction treatment facilities. Murphy's bill would extend ARRA EMR incentives to these facilities. APA's support letter can be accessed at *www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/APA%20on%20the%20Issues/7-9-2012-APA-HITECH-extension-support-letter-house.pdf.*

Schizophrenia can tear patients apart

For the treatment of schizophrenia

LATUDA can help put your patients back together

- Symptom improvement was established in several pivotal trials[1]
- The safety and tolerability of LATUDA were evaluated in pivotal trials and multiple studies up to 52 weeks[1]
- The recommended starting dose, 40 mg/day, is an effective dose with no initial dose titration required. The maximum recommended dose is 160 mg/day[1]
  - LATUDA should be taken with food (at least 350 calories)
  - Dose adjustment is recommended in moderate and severe renal and hepatic impairment patients. The recommended starting dose is 20 mg. The dose in moderate and severe renal impairment patients and in moderate hepatic impairment patients should not exceed 80 mg/day. The dose in severe hepatic impairment patients should not exceed 40 mg/day
  - LATUDA should not be used in combination with strong CYP3A4 inhibitors such as ketoconazole or strong CYP3A4 inducers such as rifampin. When coadministered with a moderate CYP3A4 inhibitor such as diltiazem, the recommended starting dose of LATUDA is 20 mg/day and the maximum recommended dose is 80 mg/day

INDICATIONS AND USAGE

LATUDA is an atypical antipsychotic indicated for the treatment of patients with schizophrenia. Efficacy was established in five 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

See full prescribing information for complete boxed warning.

- **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 patients with dementia-related psychosis.**

Please see additional Important Safety Information, including **Boxed Warning**, and Brief Summary of Prescribing Information on adjacent pages.

SUNOVION

Latuda®
(lurasidone HCl) tablets
20mg | 40mg | 80mg

INDICATIONS AND USAGE

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CONTRAINDICATIONS

LATUDA is contraindicated in the following:

- Any patient with a known hypersensitivity to lurasidone HCl or any components in the formulation. Angioedema has been observed with lurasidone.
- Concomitant use with strong CYP3A4 inhibitors (e.g., ketoconazole).
- Concomitant use with 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. Orthostatic vital signs should be monitored in patients who are vulnerable to hypotension and in patients with known cardiovascular disease or cerebrovascular disease.

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 17.0% (256/1508) of patients treated with LATUDA compared to 7.1% (50/708) of placebo patients, respectively. 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 and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia.

ADVERSE REACTIONS

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

Please see brief summary of prescribing information on adjacent pages, including **Boxed Warning**.

Reference: 1. LATUDA prescribing information. Sunovion Pharmaceuticals Inc. April 2012.

FOR MORE INFORMATION, PLEASE CALL 1-888-394-7377 OR VISIT **www.LatudaHCP.com**.

Brief Summary (for Full Prescribing Information, see package insert)

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 *[See Warning and Precautions (5.1)]*.**
- **LATUDA is not approved for use in patients with dementia-related psychosis *[See Warning 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 five 6-week controlled studies of adult patients with schizophrenia *[see Clinical Studies (14.1)]*.

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 (2)]*.

4 CONTRAINDICATIONS

LATUDA is contraindicated in the following:

- Any patient with a known hypersensitivity to lurasidone HCl or any components in the formulation. Angioedema has been observed with lurasidone *[see Adverse Reactions (6.1)]*.
- Concomitant use with strong CYP3A4 inhibitors (e.g., ketoconazole) *[see Drug Interactions (7.1)]*.
- Concomitant use with 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. 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 Boxed Warning]*.

5.2 Cerebrovascular Adverse Reactions, Including Stroke in Elderly Patients with Dementia-Related Psychosis

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

		LATUDA				
	Placebo	20 mg/day	40 mg/day	80 mg/day	120 mg/day	160 mg/day
Mean Change from Baseline (mg/dL)						
	n=680	n=71	n=478	n=508	n=283	n=113
Serum Glucose	–0.0	–0.6	2.6	–0.4	2.5	2.5
Proportion of Patients with Shifts to ≥ 126 mg/dL						
Serum Glucose (≥ 126 mg/dL)	8.3% (52/628)	11.7% (7/60)	12.7% (57/449)	6.8% (32/472)	10.0% (26/241)	5.6% (6/108)

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in glucose of +1.8 mg/dL at week 24 (n=355), +0.8 mg/dL at week 36 (n=299) and +2.3 mg/dL at week 52 (n=307).

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

		LATUDA				
	Placebo	20 mg/day	40 mg/day	80 mg/day	120 mg/day	160 mg/day
Mean Change from Baseline (mg/dL)						
	n=660	n=71	n=466	n=499	n=268	n=115
Total cholesterol	–5.8	–12.3	–5.7	–6.2	–3.8	–6.9
Triglycerides	–13.7	–29.1	–5.1	–13.0	–3.1	–10.6
Proportion of Patients with Shifts						
Total Cholesterol (≥ 240 mg/dL)	5.3% (30/571)	13.8% (8/58)	6.2% (25/402)	5.3% (23/434)	3.8% (9/238)	4.0% (4/101)
Triglycerides (≥ 200 mg/dL)	10.1% (53/526)	14.3% (7/49)	10.8% (41/379)	6.3% (25/400)	10.5% (22/209)	7.0% (7/100)

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in total cholesterol and triglycerides of –3.8 (n=356) and –15.1 (n=357) mg/dL at week 24, –3.1 (n=303) and –4.8 (n=303) mg/dL at week 36 and –2.5 (n=307) and –6.9 (n=307) 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 0.43 kg for LATUDA-treated patients compared to –0.02 kg for placebo-treated patients. Change in weight from baseline for olanzapine was 4.15 kg and for quetiapine extended-release was 2.09 kg in Studies 3 and 5 *[see Clinical Studies (14.1)]*, respectively. The proportion of patients with a ≥ 7% increase in body weight (at Endpoint) was 4.8% for LATUDA-treated patients versus 3.3% for placebo-treated patients.

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

		LATUDA				
	Placebo (n=696)	20 mg/day (n=71)	40 mg/day (n=484)	80 mg/day (n=526)	120 mg/day (n=291)	160 mg/day (n=114)
All Patients	–0.02	–0.15	0.22	0.54	0.68	0.60

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in weight of –0.69 kg at week 24 (n=755), –0.59 kg at week 36 (n=443) and –0.73 kg at week 52 (n=377).

5.6 Hyperprolactinemia

As with other drugs that antagonize dopamine D2 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 0.4 ng/mL and was –1.9 ng/mL in the placebo-treated patients. The median change from baseline to endpoint for males was 0.5 ng/mL and for females was –0.2 ng/mL. Median changes for prolactin by dose are shown in Table 4.

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

		LATUDA				
	Placebo	20 mg/day	40 mg/day	80 mg/day	120 mg/day	160 mg/day
All Patients	–1.9 (n=672)	–1.1 (n=70)	–1.4 (n=476)	–0.2 (n=495)	3.3 (n=284)	3.3 (n=115)
Females	–5.1 (n=200)	–0.7 (n=19)	–4.0 (n=149)	–0.2 (n=150)	6.7 (n=70)	7.1 (n=36)
Males	–1.3 (n=472)	–1.2 (n=51)	–0.7 (n=327)	–0.2 (n=345)	3.1 (n=214)	2.4 (n=79)

The proportion of patients with prolactin elevations ≥ 5× upper limit of normal (ULN) was 2.8% for LATUDA-treated patients versus 1.0% for placebo-treated patients. The proportion of female patients with prolactin elevations ≥ 5x ULN was 5.7% for LATUDA-treated patients versus 2.0% for placebo-treated female patients. The proportion of male patients with prolactin elevations > 5x ULN was 1.6% 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 –0.9 ng/mL at week 24 (n=357), –5.3 ng/mL at week 36 (n=190) and –2.2 ng/mL at week 52 (n=307).

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 (13)]*. 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.

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 [0.3% (5/1508), 0.1% (1/708)] and syncope [0.1% (2/1508), 0%]. Assessment of orthostatic hypotension was 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, 2.1% with LATUDA 80 mg, 1.7% with LATUDA 120 mg and 0.8% with LATUDA 160 mg compared to 0.7% with placebo.

Orthostatic vital signs should be monitored in patients who are vulnerable to hypotension (e.g. dehydration, hypovolemia, and treatment with antihypertensive medications), and in patients with known cardiovascular disease (e.g., heart failure, history of myocardial infarction, ischemia, or conduction abnormalities), or cerebrovascular disease.

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 1.0% (2/1508) of patients treated with LATUDA compared to 0.1% (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 by 17.0% (256/1508) of patients treated with LATUDA (15.5% LATUDA 20 mg, 15.6% LATUDA 40 mg, 15.2% LATUDA 80 mg, 26.5% LATUDA 120 mg and 8.3% LATUDA 160 mg/day) compared to 7.1% (50/708) of placebo patients. 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 0.4% (6/1508) for LATUDA-treated patients compared to 0.8% (6/708) 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 and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia.

5.14 Use in Patients with Concomitant Illness

Clinical experience with LATUDA in patients with certain concomitant illnesses is limited *[see Clinical Pharmacology (12.3)]*.

Patients with Parkinson's Disease or Dementia with Lewy Bodies are reported to have an increased sensitivity to antipsychotic medication. Manifestations of this increased sensitivity include confusion, obtundation, postural instability with frequent falls, extrapyramidal symptoms, and clinical features consistent with the neuroleptic malignant syndrome.

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 trials. Because of the risk of orthostatic hypotension with LATUDA, caution should be observed in patients with known cardiovascular disease *[see Warnings and Precautions (5.8)]*.

6 ADVERSE REACTIONS

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)]*

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

The information below is derived from a clinical study database for LATUDA consisting of 2905 patients with schizophrenia exposed to one or more doses with a total experience of 985.3 patient-years. Of these patients, 1508 participated in short-term, placebo-controlled schizophrenia studies with doses of 20 mg, 40 mg, 80 mg, 120 mg or 160 mg once daily. A total of 769 LATUDA-treated patients had at least 24 weeks and 371 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 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 160 mg (n=1508).

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 and parkinsonism.

Adverse Reactions Associated with Discontinuation of Treatment: A total of 9.5% (143/1508) LATUDA-treated patients and 9.3% (66/708) 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=708)**	**All LATUDA (N=1508)**
Gastrointestinal Disorders		
Nausea	5	10
Vomiting	6	8
Dyspepsia	5	6
Salivary Hypersecretion	<1	2
Musculoskeletal and Connective Tissue Disorders		
Back Pain	2	3
Nervous System Disorders		
Somnolence*	7	17
Akathisia	3	13
Parkinsonism**	5	10
Dizziness	2	4
Dystonia***	<1	5
Psychiatric Disorders		
Insomnia	8	10
Agitation	4	5
Anxiety	4	5
Restlessness	1	2

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

Dose-Related Adverse Reactions

In pooled data from the short-term, placebo-controlled, fixed-dose studies, there were no dose-related adverse reactions (greater than 5% incidence) in patients treated with LATUDA across the 20 mg/day to 160 mg/day dose range. However, the frequency of akathisia increased with dose up to 120 mg/day (5.6% LATUDA 20 mg, 10.7% LATUDA 40 mg, 12.3% LATUDA 80 mg, 22.0% LATUDA 120 mg); akathisia was reported by 7.4% (9/121) of patients receiving 160 mg/day. Akathisia occurred in 3.0% of subjects receiving placebo.

Extrapyramidal Symptoms

In the short-term, placebo-controlled schizophrenia studies, for LATUDA-treated patients, the incidence of reported events related to extrapyramidal symptoms (EPS), excluding akathisia and restlessness, was 13.5% versus 5.8% for placebo-treated patients. The incidence of akathisia for LATUDA-treated patients was 12.9% versus 3.0% for placebo-treated patients. Incidence of EPS by dose is provided in Table 6.

Table 6: Incidence of EPS Compared to Placebo

		LATUDA				
Adverse Event Term	**Placebo (N=709) (%)**	**20 mg/day (N=71) (%)**	**40 mg/day (N=487) (%)**	**80 mg/day (N=538) (%)**	**120 mg/day (N=291) (%)**	**160 mg/day (N=121) (%)**
All EPS events	**9**	**10**	**21**	**26**	**39**	**20**
All EPS events, excluding Akathisia/ Restlessness	**7**	**6**	**14**	**13**	**24**	**14**
Akathisia	3	6	11	12	22	7
Dystonia*	<1	0	4	5	7	2
Parkinsonism**	5	6	9	8	17	11
Restlessness	1	1	3	1	3	2

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, 0.1; 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, 14.4%; placebo, 7.1%) and the SAS (LATUDA, 5.0%; placebo, 2.3%).

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.

In the short-term, placebo-controlled clinical trials, dystonia occurred in 4.2% of LATUDA-treated subjects (0.0% LATUDA 20 mg, 3.5% LATUDA 40 mg, 4.5% LATUDA 80 mg, 6.5% LATUDA 120 mg and 2.5% LATUDA 160 mg) compared to 0.8% of subjects receiving placebo. Seven subjects (0.5%, 7/1508) discontinued clinical trials due to dystonic events – four were receiving LATUDA 80 mg/day and three were receiving LATUDA 120 mg/day.

Other Adverse Reactions Observed During the Premarketing Evaluation of LATUDA

Following is a list of 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 2905 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 or those that appear elsewhere in the LATUDA label are not included. Although the reactions reported occurred during treatment with LATUDA, they were not necessarily caused by it.

Reactions are further categorized by 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).

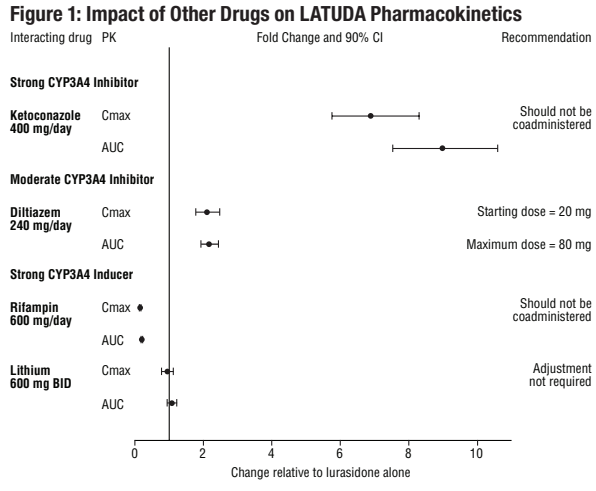
Blood and Lymphatic System Disorders: ***Infrequent:*** *anemia;*
Cardiac Disorders: ***Frequent:*** *tachycardia;* ***Infrequent:*** *AV block 1st degree, angina pectoris, bradycardia*
Ear and Labyrinth Disorders: ***Infrequent:*** *vertigo*
Eye Disorders: ***Frequent:*** *blurred vision*
Gastrointestinal Disorders: ***Frequent:*** *abdominal pain, diarrhea;* ***Infrequent:*** *gastritis,*
General Disorders and Administrative Site Conditions: ***Rare:*** *sudden death*
Investigations: ***Frequent:*** *CPK increased*
Metabolism and Nutritional System Disorders: ***Frequent:*** *decreased appetite*
Musculoskeletal and Connective Tissue Disorders: ***Rare:*** *rhabdomyolysis*
Nervous System Disorders: ***Infrequent:*** *cerebrovascular accident, dysarthria,*
Psychiatric Disorders: ***Infrequent:*** *abnormal dreams, panic attack, sleep disorder;*
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: ***Frequent:*** *hypertension;*

7 DRUG INTERACTIONS

7.1 Potential for Other Drugs to Affect LATUDA

LATUDA is predominantly metabolized by CYP3A4. LATUDA should not be used in combination with strong inhibitors or inducers of this enzyme *[see Contraindications (4)]* and dose should be limited when used in combination with moderate inhibitors of CYP3A4 *[see Dosage and Administration (2.4)]*. No dose adjustment is needed with concomitant use of lithium (see Figure 1).

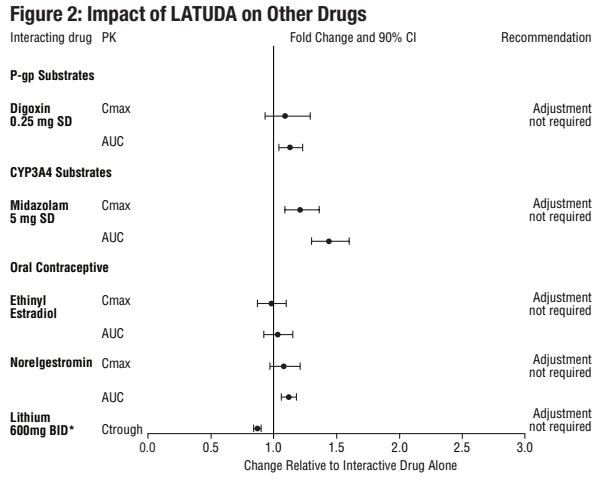
Figure 1: Impact of Other Drugs on LATUDA Pharmacokinetics



7.2 Potential for LATUDA to Affect Other Drugs

No adjustment is needed on the dose of lithium, or substrates of P-gp or CYP3A4 when coadministered with LATUDA (Figure 2).

Figure 2: Impact of LATUDA on Other Drugs



*Steady state lithium Ctrough on Day 4 vs Day 8 when lithium was coadministered with lurasidone at steady state

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Teratogenic Effects

Pregnancy Category B

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

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.

Safe use of LATUDA during pregnancy or lactation has not been established; therefore, use of LATUDA in pregnancy, in nursing mothers, or in women of childbearing potential requires that the benefits of treatment be weighed against the possible risks to mother and child.

Animal Data

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

No teratogenic effects were seen in studies in which pregnant rats and rabbits were given LATUDA during the period of organogenesis at doses up to 25 and 50 mg/kg/day, respectively. These doses are 1.5 and 6 times, in rats and rabbits respectively, the maximum recommended human dose (MRHD) of 160 mg/day based on body surface area.

8.3 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. Because of the potential for serious adverse reactions in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the drug, considering risk of drug discontinuation to the mother.

8.4 Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

8.5 Geriatric Use

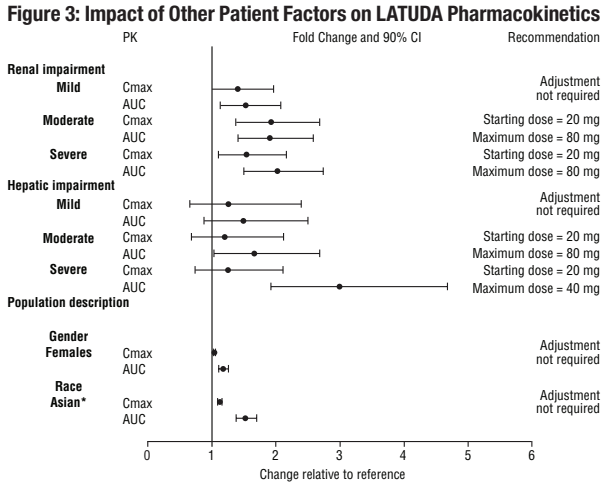
Clinical studies of LATUDA in the treatment of schizophrenia did not include sufficient numbers of patients aged 65 and older to determine whether or not they respond differently from younger patients. In elderly patients with psychosis (65 to 85), LATUDA concentrations (20 mg/day) were similar to those in young subjects *[see Clinical Pharmacology (12.3)]*. No dose adjustment is necessary in elderly patients (Figure 2).

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]*.

8.6 Other Patient Factors

The effect of intrinsic patient factors on the pharmacokinetics of LATUDA is presented in Figure 3.

Figure 3: Impact of Other Patient Factors on LATUDA Pharmacokinetics



*Compare to Caucasian

10 OVERDOSAGE

10.1 Human Experience

In premarketing clinical studies involving 2905 patients, 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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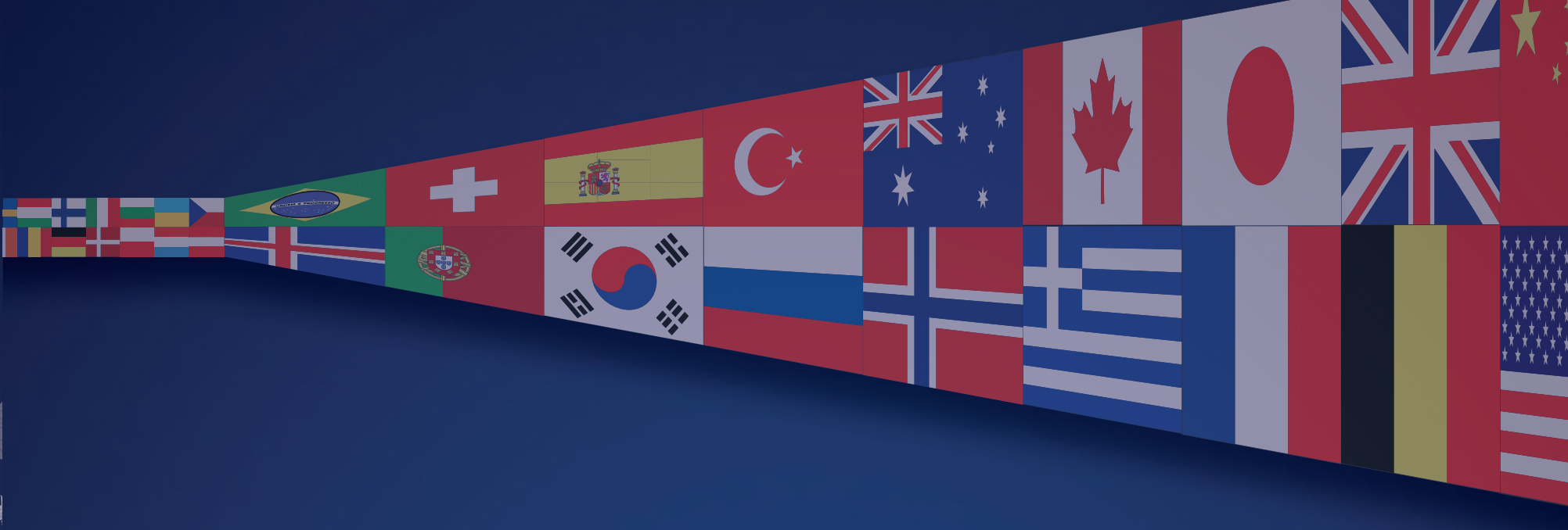

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LETTERS TO THE EDITOR

Certification Language Matters

The April 20 issue contains an article about the Maintenance of Certification (MOC) Program written by leaders of the American Board of Psychiatry and Neurology ("ABPN Leaders Explain Goals, Background of MOC Program"), which contains some disturbing information.

The article states, "Lifetime certificate holders who do not participate in the MOC Program will be listed as 'Certified but Not Meeting MOC Requirements.' " In my opinion, that phrase has the potential to stigmatize psychiatrists who have chosen not to pursue MOC.

The article does explain that "[t]here will be a special note that meeting MOC requirements is not mandatory for lifetime certificate holders." However, I do not believe this additional note will soften the reaction of a patient or attorney who has already read the stigmatizing phrase "Certified but Not Meeting MOC Requirements." The word "but" suggests something less than full certification.

Certainly, lifetime certificate holders who choose to participate in the MOC Program should be recognized. I propose that the ABPN consider a system in which lifetime members who pursue MOC would be recognized without stigmatizing those who do not. Instead of using the proposed language, the ABPN could list lifetime members as either "Certified" or "Certified and Meeting MOC requirements."

The special note, explaining that meeting MOC requirements is not mandatory, could still be included and in this context would emphasize the additional efforts of those who pursue MOC without stigmatizing those who choose not to do so.

JEFFREY WEINER, M.D.
San Mateo, Calif.

Response from Mary Helen Davis, M.D., chair of the APA Board of Trustees Work Group on Maintenance of Certification:

Dr. Jeffrey Weiner must be a seasoned psychotherapist given his response to the recent Maintenance of Certification Program article; as such, he understands the value of words and the power of stigmatization and of stating accomplishments in the positive versus use of prepositions that qualify the value of one's certification. His offered solution seems reasonable and logical, at least as a temporary salve to those of us who have grandfathered status and ambivalence about the MOC process.

Unfortunately many of us in the practice of psychiatry have been siloed from the regulatory changes that have faced the rest of medicine and are now knocking on our door. This change is global, from maintenance of licensure to institutional accreditations; the practice of medicine is evolving, and regulatory mandates are following on the heels of this change. Certification has become a track-and-field event; every time you clear the bar, it is raised. Failure to attempt the jump or clear the bar will ultimately have consequences down the road. The gamble is on how long and how far down the road those consequences might impact one's practice. Having followed health care policy and trends, I can say that, for better or worse, the pace of change is accelerating and perhaps the best time to change is prior to being forced.

Nonetheless, if my assumption is accurate and Dr. Weiner is a seasoned psychotherapist, he will have plenty of job security treating physicians across multiple specialties for demoralization as they adapt or choose not to adapt to the myriad changes coming down the health care trend track.

Response from James R. (Bob) Batterson, M.D., chair of the Assembly Committee on Maintenance of Certification:

Dr. Weiner's letter highlights the concerns of many APA members about changes coming from the ABPN. From the earliest announcement of the new MOC Program with Performance in Practice (PIP) guidelines, APA's Assembly has been discussing the problems that will likely be encountered, and action papers have been written on the topic. During APA's 2012 annual meeting, the Assembly voted that the ABPN be asked to delay implementation of the PIP portion of MOC to allow more time to gather scientific evidence showing that it would improve quality of care. Due to the reporting requirements that the American Board of Medical Specialties places on the ABPN regarding physician participation in MOC, it seems likely that the reporting of whether we are or are not meeting MOC requirements will be implemented. Dr. Weiner's suggestion of a way to do this that respects the lifetime certification while still being able to report participation in MOC deserves serious consideration by the ABPN. Perhaps the ABPN can look for guidance from other medical boards, such as the American Board of Pediatrics, where there is a statement of certification or not, year certified, and the MOC requirements currently being met or not. The ABPN could use the term "Lifetime Certified" or "Certified." I hope that Dr. Weiner will contact his Assembly representative and suggest an action paper for the November Assembly meeting. PN

Letters Invited

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

GID

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or longitudinal studies; control studies in which a group of patients and a group of control subjects are identified in the present, and information is pursued retrospectively; reviews with secondary data analysis; and opinion-like essays or case reports.

The task force found no randomized, controlled trials pertaining to any treatment intervention in adults. And there is no universal agreement regarding treatment goals other than improving the sense of well-being and overall functioning of the individual. Most of the literature addressing psychotherapy with gender variant adults consists of case reports and review articles without additional data analysis.

"This body of work nevertheless identifies the major issues that should be addressed in psychotherapy with these individuals," the task force stated in its report. "Overall, the evidence suggests that sex reassignment is associated with an improved sense of well-being in the majority of cases and also indicates correlates of satisfaction and regret."

No studies have directly compared various levels of mental health screening prior to hormonal and surgical treatments on outcome variables; however, studies suggest that comprehensive mental health screening may be successful in identifying individuals most likely to experience regrets, according to the report.

The task force concluded that with subjective improvement as the primary outcome measure, the existing evidence base combined with clinical consensus is sufficient for developing recommendations in the form of an APA practice guideline for treatment of adults. Such a guideline might address assessing and diagnosing patients' gender concerns according to *DSM* criteria; assessing and diagnosing coexisting psychopathology; distinguishing manifestations that are not part of GID but epiphenomena of psychopathology; and engaging in psychotherapy with gender variant individuals, among other issues.

> "Sex reassignment is associated with an improved sense of well-being in the majority of cases and also indicates correlates of satisfaction and regret."

With regard to disorders of sex development (DSD), the task force found that the absence of systematic studies linking particular interventions to mental health outcome variables largely limits the development of practice recommendations for DSDs to treatment recommendations based on clinical consensus. Byne said that the birth of a child with ambiguous genitalia should involve the expertise of psychiatrists and that treatment recommendations based on existing clinical consensus will be useful to clinicians.

"Until recently, the birth of a child with an intersex condition has often been perceived as a 'psychiatric emergency in the emergency department,' yet a psychiatrist or other mental health professional has not typically been involved," Byne said. "Instead there has often been a rush to perform irreversible genital surgeries at a time when parents might be in a state of shock and unable to give truly informed consent.

"Ideally, psychiatrists or other mental health professionals should be called on early," he said. "In the absence of a medical emergency, they can counsel against taking irreversible actions in a crisis atmosphere. If the child is healthy, there is time to calm down, reassure the parents, and help them think through the options carefully while providing them support as well as the psychoeducation they need to make informed decisions about the treatment of their child." PN

"Report of the APA Task Force on Treatment of Gender Identity Disorder" can be accessed at *http://www.psychiatry.org/learn/library--archives/resource-documents*.

Elderly

continued from page 1

APA, and others, noted that the Environmental Catchment Area Study in 1991 estimated that 13 percent of the elderly met criteria for mental disorders. However, adding to that figureexpected higher generational rates of depression, anxiety, substance use, and dementia would mean that closer to 22 percent of the elderly is likely to have a psychiatric or substance use disorder by 2030, they wrote.

> "We're now at the edge of an emerging crisis. The burden of illness among older persons is significant, and the pressures on primary care, nursing homes, and direct care will increase."

"People are not thinking about this now, but the baby boomers will demand dealing with it," said geriatric psychiatrist Laurence Miller, M.D., medical director of the Division of Behavioral Health Services in Arkansas and a clinical professor of psychiatry at the University of Arkansas for Medical Sciences in Little Rock. Miller was not involved with the IOM study.

"The behavioral health workforce is insufficient now," said Miller. "As the elderly population explodes, the shortage will only get worse."

Those inadequacies are excaerbated by "a conspicuous lack of national attention" to the problem, said the report. A "disconcertingly small" number of providers are going into geriatrics now, "dwarfed by the pace at which the population is growing."

Reimbursement Levels Inadequate

"Most professionals who work with older adults say they like their work, but reimbursement remains a problem," said Blazer. "It just doesn't pay as well as, say, child psychiatry, especially under Medicare."

Professional training connecting mental health and geriatrics is inadequate, the panel's report emphasized.

The elderly population has specific needs, Miller noted. They present with general medical as well as psychiatrically complicated conditions, yet geriatric fellowships go unfilled.

"So because there are not enough geriatric psychiatrists, we have to think creatively," Miller told *Psychiatric News*. "We have to take a population-based, rather than a patient-based approach."

Yet delivery and reimbursement systems have so far not adjusted to this reality.

For instance, some evidence-based models of depression treatment rely on care managers to coordinate the efforts of primary care physicians, psychiatrists, and social workers. However, Medicare currently does not pay for the care managers' time, despite their demonstrated value. Nor does the system reimburse a psychiatrist who consults with the care manager or the primary care clinician but does not see the patient directly, said Blazer.

The Centers for Medicare and Medicaid Services is exploring alternative models of care but has not changed its policies yet, he pointed out.

Government Efforts Lack Coordination

Finally, attempts to expand and improve the workforce to care for older people with mental health or substance use problems are seriously hampered by a dispersal of responsibility across numerous federal government agencies, said the report.

For instance, the Health Resources and Services Administration is supposed to promote health care workforce development, but its geriatric training programs include nothing on mental health or substance abuse conditions, according to the report. Only a small part of the Substance Abuse and Mental Health Services Administration's (SAMHSA) budget is aimed at the elderly, and the agency has eliminated the Older Adults Targeted Capacity Expansion grants program.

"And it's very telling that the National Institute on Aging didn't see mental health and substance abuse issues among the elderly as their area of interest," Miller said.

The previously authorized National Health Care Workforce Commission could use existing law and serve as a central coordinating body for federal efforts—if it were funded by Congress, said the report. Until then, the secretary of Health and Human Services should designate a responsible entity to do so.

How soon that might happen is unclear, said Blazer. "But we have made the recommendations to get the process started."

"I'd like to see SAMHSA take the lead and work with other agencies, but such a coordinated federal response seems unlikely to happen soon," Miller suggested.

"As a geriatric psychiatrist, I strongly support the findings and recommendations of this new IOM report on aging and mental health and substance use disorders," said Jeste, a professor of psychiatry and neurosciences at the University of California, San Diego, in a recent statement. "The American Psychiatric Association hopes that necessary changes are implemented soon to provide badly needed care for our elderly patients, particularly those with financial needs who are among the most disenfranchised sectors of our society." PN

"The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?" is posted at *www.iom.edu/Reports/2012/The-Mental-Health-and-Substance-Use-Workforce-for-Older-Adults.aspx*.

Consensus

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address the following: psychological and psychiatric assessment and diagnosis of adolescents presenting with a wish for sex reassignment, assessment of indications and readiness for suspension of puberty and/or cross-sex hormones as well as provision of documentation to specialists in other disciplines involved in caring for the adolescent, psychoeducation of family members, and assessment of the safety of the family/school/community environment in terms of bullying and stigmatization.

(The American Academy of Child and Adolescent Psychiatry has developed the "Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender-Nonconformity, and Gender Discordance in Children and Adolescents," which is posted at *www.aacap.org/galleries/PracticeParameters/glbt_practice_parameter_june_2012.pdf*.)

Menvielle told *Psychiatric News* that one treatment for early adolescents around which there is an emerging database—largely from Toronto and the Netherlands—is the use of pubertal suspension. He explained that the therapy involves a pharmacologic intervention at an early stage of puberty to prevent the development of secondary sex characteristics and to provide time for the child, parents, and clinician to decide whether to institute cross-sex hormone treatment.

"We want APA members and other clinicians to be aware that the treatment exists, and that child and adolescent psychiatrists have a role in this therapy," he said.

The report notes that between 2001 and 2009, more than 80 adolescents had been treated with pubertal suspension "with overall positive results in the most detailed follow-up study published to date." A practice guideline developed by the Endocrine Society suggests that pubertal suspension can be done for a period of up to several years "during which time the patient, with the clinician, can decide whether it is preferable for the adolescent to revert to living in the birth sex or to continue gender transition with cross-sex hormone therapy," according to the report.

"Most clinicians who treat transgender patients understand that the goal of treatment is not to attempt to change the gender identity but to provide whatever the patients need to express their gender identity in a way that makes sense to them and helps them lead productive and fulfilling lives," Menvielle said. PN

Solitary Confinement

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In addition to underscoring the need for a rethinking of solitary-confinement practices, these statistics reflect the current dearth of segregation-unit psychiatric physicians capable of treating prisoners living in such extreme conditions, Scully emphasized in his testimony.

"APA believes that any initiative to address the practice of solitary confinement in the United States must also address the physician's ethical responsibility to provide the highest level of medical and mental health care to incarcerated patients," Scully said. "This entails greater investments in the psychiatric physician workforce, enhanced efforts to educate all physicians about correctly diagnosing and treating mental illness, and repurposed space in prison segregation units that ensures that patients receive appropriate confidential evaluation, consultation, and treatment services." PN

The full text of APA's comments is posted at *www.psych.org/File%20Library/Advocacy%20and%20Newsroom/APA%20on%20the%20Issues/Regulatory/06-19-12-APA-Statement-on-Solitary-Confinement.pdf*.

Alzheimer's

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complex relationship with Alzheimer's. Late-onset depression is a warning sign, said Sperling. "But it's not clear if Alzheimer's is a risk factor for depression or if depression is an early symptom of Alzheimer's," she said.

"Depression is the most common psychiatric condition associated with dementia, and the usual antidepressant treatments don't work as well for these patients," added Hodes in an interview.

Sperling also speculated on parallels between Alzheimer's and schizophrenia. Both have positive and negative symptoms. Hallucinations and delusions are not uncommon in both, and each is manifested in hippocampal and learning dysfunctions. In addition, schizophrenia appears in one (early) developmental stage in life, while Alzheimer's arises in a later, "de-developmental" stage. Both represent failures in neural networks, she said.

The only protective factors against Alzheimer's known so far appear to be increased physical activity or memory training, but more and larger randomized controlled trials are needed to confirm those effects, said Albert.

Simply recognizing cognitive decline isn't enough, Hodes emphasized. The Affordable Care Act requires "detection of cognitive impairment," but offers no help with which tests to employ, not to mention false positives, distressing diagnostic procedures, or what interventions (if any) are appropriate.

Interventions in cancer, stroke, HIV disease, diabetes, and osteoporosis now include preventive measures before symptoms appear. A similar approach should direct research into age-related brain changes. "We have to increase the quality and quantity of the evidence, but we can also act on what we know so far," said Hodes. PN

A video of the Neuroscience and Society Series, presented by the AAAS and the Dana Foundation is posted at *http://dana.org/events/detail.aspx?id=39130*.

Quest

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psychiatrists, like the lone practitioner on the island nation of Kiribati in the South Pacific.

He noted that many countries allocate few resources to health in general and even less to mental health.

"We come from an elite mentality about psychiatric care, but that is wrong," he said. "Many psychiatrists around the world are doing the best they can with the minimal resources they have."

Van likes different places for different reasons. One country might have beautiful scenery, another may be home to an old civilization, while a third simply has people with whom he enjoys talking.

"I love islands where the mountains and the sea are close together," he said. That includes place like Bora Bora or Fiji in the South Pacific, Lord Howe Island off the coast of Australia, or Reunion Island in the Indian Ocean.

He politely demurs on naming the worst place he's visited, except to say he was afraid to go out at night there.

Next on his list was to be the territory of Nakhichevan, an enclave of Azerbaijan entirely surrounded by Armenia and the subject of a brief armed conflict between the two countries in 1992. However, his request for a visa was denied, delaying that trip indefinitely.

What lessons can this traveler to antique and modern lands offer to those dreaming to take off on their own voyages?

"The more you travel and meet people, the more you find they're the same," he said. "They all want happiness. They all want things better for their kids. Also, the poorer the place, the more heart the people have, and the more they share with you the little they have." PN

From the Experts

continued from page 16

less facile in using the Internet, this is fast changing, and the acceptability of computers by the elderly will only increase.

If a problem is identified and has not reached a severe level, the clinician can have a frank and honest discussion with the older patient followed by a brief intervention, such as brief motivational therapy. In more serious cases, the usual approaches to treating substance use disorders, including residential rehab programs, can be prescribed. If the clinician gets the family involved, then older adults are more willing to yield to the views of both psychiatrist and family that the problem is serious and must be addressed as soon as possible. PN

Dan Blazer, M.D., Ph.D., is the J.P. Gibbons Professor of Psychiatry and Behavioral Sciences at Duke University Medical Center. He can be reached at dan.g.blazer@dm.duke.edu. He is also the main editor of the *Textbook of Geriatric Psychiatry* from American Psychiatric Publishing. APA members can purchase the book at a discount at *www.appi.org//SearchCenter/Pages/SearchDetail.aspx?Itemid=562375*.

Colorado Shooting

continued from page 1

dead. "We're seeing an increase in referred and self-identified people with Columbine exposure," said Donald Bechtold, M.D.

Bechtold was a faculty member at the University of Colorado in 1999 and helped out at the Jefferson Center for Mental Health in Wheat Ridge, Colo., which was the focal point for mental health response to the Columbine tragedy.

Clinicians back then screened students and others exposed to the event, said Bechtold, now vice president and medical director at the Jefferson Center.

"We supported safe, neutral places for people in the community to come together to talk," he said. "We did some psychoeducation to help them understand their reactions and let them know that [their reaction to the shootings] would be a long-term issue that would change over time and not resolve right away."

Each situation is different and requires a different response, said Bechtold. For instance, Columbine took place in one high school, while the victims in the Aurora movie theater came from a number of schools, colleges, and workplaces.

The primary lesson from Columbine was not some clinical pearl, he said. "It's the need for communities and states to have good disaster plans in place, so that when an event happens, you're not left to scramble."

As part of those plans, Jefferson had a group of licensed clinicians who had volunteered well in advance of the Aurora incident to serve wherever they might be needed. Jefferson supported their time and covered their schedules while they were in Aurora.

A week after the shooting, in a Centennial, Colo., courtroom, James Holmes, a former graduate student in neuroscience at the University of Colorado, Denver, was charged with 24 counts of murder and 116 counts of attempted murder, plus weapons and explosives charges. A trial is not expected before next year.

Judge William Sylvester scheduled a hearing for August 9 on the gag order that has kept nearly all information about the case under wraps. An August 16 hearing was scheduled to address the status of a notebook Holmes allegedly mailed to Lynne Fenton, M.D., a university student health service psychiatrist first identified by defense lawyers as having seen Holmes.

Some media commentators criticized Fenton for failing to predict or prevent the violence.

Such criticism is misplaced, said former APA President Paul Appelbaum, M.D., the Dollard Professor of Psychiatry, Medicine, and Law and director of the Division of Law, Ethics, and Psychiatry in the Department of Psychiatry at Columbia University College of Physicians and Surgeons.

For one thing, almost nothing is publicly known so far about Holmes' condition or Fenton's professional interaction with him, he said.

"Was Holmes seen once or over a period of time?" said Appelbaum. "What was the presenting problem? What, if any, treatment was provided? We don't know."

> "We don't limit our services to people directly affected by the shooting. There is a lot of secondary trauma with people listening to the news or having memories of Columbine triggered off."

At *Psychiatric News'* press time, the Associated Press, citing a Denver TV station, reported that early in June Fenton had notified members of the university's Behavior Evaluation and Threat Assessment team about Holmes. The team did not meet to discuss his case because Holmes dropped out of the school on June 10.

Regarding the notebook's status, some therapist-patient communications are protected from disclosure and some are not, said Appelbaum. If the notebook was sent in connection with treatment, it would remain privileged. But if it was seen as, say, a farewell message from the patient, it would not. In such cases, the judge alone reviews the material and decides whether it is privileged.

In any case, if a defendant asserts an insanity defense, privilege may be abrogated and the psychiatrist can testify at trial, he said.

As the judicial process moves ahead slowly, work continues at the Aurora Community Mental Health Center. Winter and her staff are prepared for the months of work ahead.

"The goal of the killer was to separate people," she said. "So it's a defiant act to bond and heal together." PN

"When Disaster Strikes," which includes information on the psychological effects of disaster and treatment, is posted on APA's Web site at *www.psychiatry.org/practice/professional-interests/disaster-psychiatry/when-disaster-strikes*. Free chapters from American Psychiatric Publishing's book *Disaster Psychiatry: Readiness, Evaluation, and Treatment* can be accessed at no charge at *www.appi.org/Pages/TreatingPatientsintheWakeofaTraumaticEvent.aspx*.

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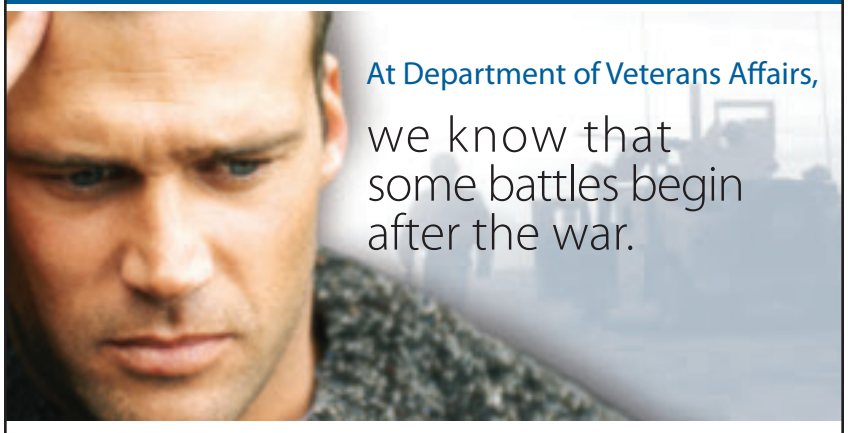

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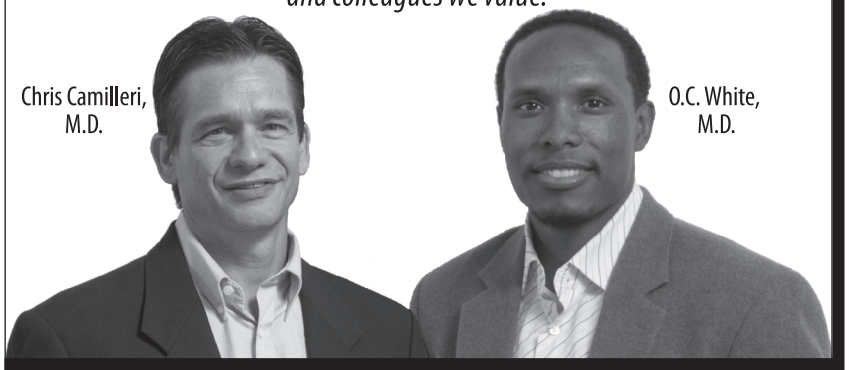

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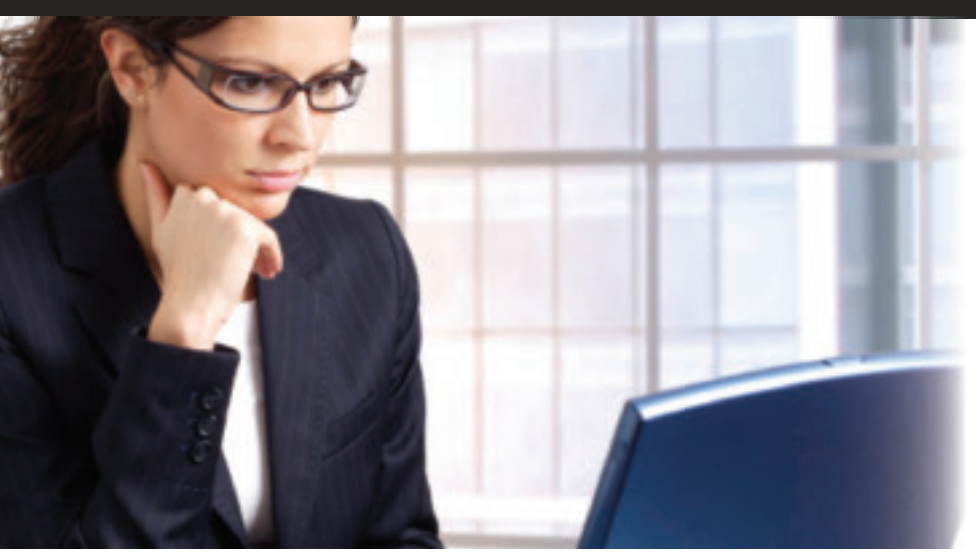

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MAINE

Adult IP Psychiatrist

MaineGeneral Medical Center in Augusta/Waterville, Maine is seeking a BC/BE adult psychiatrist with interests in inpatient psychiatry or outpatient psychiatry/substance abuse. Full-time schedule is five eight-hour days. You will be joining a staff of four employed physicians and four psychiatric nurse practitioners that provide multidisciplinary inpatient, outpatient, and consultative services. We have a 30-bed inpatient program at our Thayer Campus in Waterville, 5 Intensive Outpatient Programs in Waterville and Augusta, an ACT Team, and an outpatient program providing psychiatric and substance abuse treatment. We also provide consultative support for our inpatient medical and surgical services. We offer excellent benefits including relocation assistance, loan forgiveness, and competitive salary. We are located in scenic central Maine, just a short drive away from ski resorts, lakes and rivers, award-winning golf courses, abundant hiking trails, and the beautiful Maine coast. We are just an hour north of Portland, Maine's largest city, and three hours from Boston.

MaineGeneral is currently building a new, state-of-the-art, 192-bed regional hospital to open in late 2013 that will consolidate inpatient hospital services in Augusta. Visit ournewhospital.org for details!

Please send CV to Lisa Nutter, Physician Recruiter at lisa.nutter@mainegeneral.org, call 1-800-344-6662, or visit mainegeneral.org for more information.

MARYLAND

Medical Director

Pathways, Inc., the longest operating multi-service mental health agency in St. Mary's County, located on Maryland's western shore of the Chesapeake Bay, has an excellent opportunity for a licensed, board certified/board eligible Psychiatrist to assume the position of Medical Director in our outpatient mental health clinic. The preferred candidate will be credentialed with most major insurance companies. The selected candidate will establish and maintain appropriate standards for treatment, provide psychiatric evaluations, prescribe and manage medications, assume responsibility for the medical aspects of quality management, and provide clinical supervision to an experienced staff of clinical care providers.

St. Mary's County is designated as a Health Professional Shortage Area (HPSA) for psychiatry which qualifies service in the county for significant reduction in student loan debt. We offer a competitive wage, medical, dental, disability, and malpractice insurance, paid leave and no on-call requirement. Assistance with moving expenses is also available.

St. Mary's County is bordered by both the Patuxent and Potomac Rivers. The Southern Maryland region uniquely offers a blend of colonial history and future-oriented, technology-based industry in a location that is just south of the Baltimore-D.C corridor. It is currently the fastest growing area in the State of Maryland.

This position will require a minimum effort of twenty (20) hours per week. Salary and other terms are negotiable. If interested please submit your C.V. and letter of interest to:

Jack Dent, Administrative Officer
Pathways, Inc.
P.O. Box 129
Hollywood, MD 20636
301- 373- 3065 ext. 208
Fax 301-373-3265
E-mail jdent@pathwaysinc.org

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

CLASSIFIEDS

MASSACHUSETTS

CAMBRIDGE HEALTH ALLIANCE— Half-time child/adolescent psychiatrist for multidisciplinary Psychiatric Emergency Service at Cambridge Hospital plus consultation to community based child mental health services. In addition to child/adolescent training candidates should have experience with emergency psychiatry, comfort with screening of general medical issues, and strong skills with substance abuse populations. Interest in teaching is desired. Responsibilities include direct clinical care as well as supervision of trainees and other mental health providers. Salaried position with prorated benefits. Harvard Medical School appointment for qualified candidates. Cambridge Health Alliance is an Equal Employment Opportunity employer, and women and minority candidates are strongly encouraged to apply. CV & letter to Joel Goldstein MD, Chief, Division of Child/Adolescent Psychiatry, 1493 Cambridge Street, Cambridge, MA; Fax: 617-665-1204. Email preferred: jogoldstein@challiance.org.

CAMBRIDGE: Psychiatry Positions

Positions available at Cambridge Health Alliance Department of Psychiatry, Harvard Medical School. Full and part time opportunities in our psychiatric emergency, addictions, and outpatient services are currently available. The Department of Psychiatry at Cambridge Health Alliance is an appointing department at Harvard Medical School. Our public health commitment to improving the health of our communities, coupled with a strong academic tradition, make this an ideal opportunity for candidates interested in caring for underserved populations in a rich clinical environment. We have strong adult and child residency training programs which provide opportunities for teaching. Academic appointment, as determined by the criteria of Harvard Medical School, is anticipated.

Qualifications: BE/BC, demonstrated commitment to public sector populations, strong clinical skills, strong leadership and management skills, team oriented, problem solver. Bilingual (particularly Portuguese and Spanish) and/or bicultural abilities are desirable. Interest and experience with dual diagnosis and/or substance use disorders preferred. Child training highly desired but not required for available hours in Psychiatric Emergency Service. Suboxone certification is preferred for the addictions hours. Competitive compensation, excellent benefit package. Cambridge Health Alliance is an Equal Employment Opportunity employer, and women and minority candidates are strongly encouraged to apply. CV & letter to Susan Lewis, Department of Psychiatry, 1493 Cambridge Street, Cambridge, MA; Fax: 617-665-1204. Email preferred: SLewis@challiance.org.

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.

BOSTON locations - Westwood, Pembroke, Attleboro, Lowell and Brookline. Medical Director & Staff Positions. General, Addiction and Child. NO CALL. Inpatient & Partial. Salary, benefits & bonus opportunity. Contact Will DeCuyper, In-house recruiter @ 866-227-5415 OR email will.decuyper@uhsinc.com.

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.

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

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.

MICHIGAN

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.

MISSOURI

KANSAS CITY: Medical Director & Staff Child Psychiatrist positions. Inpatient/Partial Programs. Top salary, benefits, & bonus. Collegial staff teams. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

Small Town/Big Opportunity/35 Minutes from Springfield: Medical Director position, 10-bed Geropsych Unit. Position is inpatient, and outpatient &/or nursing homes. Very attractive salary and generous bonus plan which allows psychiatrist to make well over base salary. Very lucrative position; wonderful work environment; and a great place to live where you can have the best of both worlds-small town living and city life. Please call Terry B. Good at 1-804-684-5661, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

St. Joseph, MO - Close to Kansas City - Offering attractive student loan repayment plan: $150,000. over five years. Wonderful city to live and work and so close to the metro area. Full-time salaried position with benefits & bonus on a 24-bed adult inpatient psychiatric unit based in a very impressive general hospital. Position is inpatient, outpatient & consults. Call 1:4. H1/J1 welcome. Come join our top-notch behavioral health team! Please call Terry B. Good at 1-804-684-5661, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

NEW HAMPSHIRE

Department of Psychiatry Faculty Position

The Geisel School of Medicine at Dartmouth, Department of Psychiatry is seeking an academic geriatric psychiatrist to join its faculty at Dartmouth-Hitchcock Medical Center in Lebanon, NH.

This position will provide clinical consultations and geriatric specialty care primarily at Dartmouth-Hitchcock Medical Center. In addition, this faculty member will work closely with geriatric fellows and residents.

The ideal candidate will be a skilled clinician and enthusiastic teacher, with strong interest and experience in geriatric psychiatry. Candidates should be board certified (or eligible) in Geriatric Psychiatry. Academic rank and salary will be consistent with experience. A letter of interest, curriculum vitae and three letters of reference should be addressed to William C. Torrey

CLASSIFIEDS

MD, Vice Chair for Clinical Services for the Department of Psychiatry and chair of this search, and sent to Psychiatry.Jobs@Dartmouth.edu.

Dartmouth College is an Equal Opportunity/Affirmative Action Employer and encourages applications from women and members of minority groups.

NEW YORK CITY & AREA

Bellevue Hospital Center is seeking board certified/eligible psychiatrists for psychiatry positions on the following services: inpatient psychiatry; the outpatient clinic; and afterhours psychiatry coverage of the inpatient psychiatry service, on a salaried or moonlighting basis.

Qualified candidates are eligible for faculty appointment at a suitable rank at New York University School of Medicine. We offer competitive salary and benefits.

Our services provide compassionate, culturally sensitive care to patients with a range of diagnoses and psychosocial complexities. Access is available to a complete range of medical and specialty sought psychiatric consult services. Chinese and/or Spanish speaking psychiatrist are especially sought.

CV and inquiries should be sent to:
Mary Anne Badaracco, M.D.
Chief of Psychiatry, Bellevue Medical Center,
Department of Psychiatry
Mary.Badaracco@nyumc.org

Modern and progressive private psychiatric clinic in Downtown Manhattan is looking for p/t psychiatrists and therapists with Ph.D., Ps.D., LCSW-R level of credentials. Please email CV to nypsychiatric@yahoo.com or fax it to 212-693-4014.

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

Oregon State Hospital is looking for BC/BE psychiatrists. We have it all! A brand new hospital that incorporates modern architecture, treatment spaces, and technologies. Salary is very competitive and includes psychiatric differential, board certification pay, and opportunities for additional on-call work. OSH offers opportunities in our general adult, geriatric, and forensic programs. A generous and comprehensive benefit and PERS retirement package is included as well as opportunities to have an academic appointment with the Oregon Health Sciences University. Phone: (503) 945-2887; email: lila.m.lokey@state.or.us; fax: (503) 945-9910; www.oregon.gov/DHS/mentalhealth/osh.

The State of Oregon is an Equal Opportunity Employer.

ADOLESCENT PSYCHIATRIST P/T-F/T

Model long-term residential treatment facility for court-involved teenagers in Brooklyn. Potential leadership position. Program description at www.aichhorn.org. Inquiries: psychiatrist@aichhorn.org.

NEW YORK STATE OFFICE OF MENTAL HEALTH
KINGSBORO PSYCHIATRIC CENTER
BROOKLYN, N.Y.

Kingsboro Psychiatric Center, a major teaching center for SUNY Downstate Medical Center, seeks dedicated psychiatriststo join its staff. KPC is an Office of Mental Health operated Psychiatric Center, which provides inpatient, and outpatient services. Opportunity to work with dynamic new leadership without managed care constraints. Highly competitive salaries, comprehensive New York State employee benefits including deferred compensation, and student loan forgiveness program.No on-call required; opportunity to work extra service for salary or retirement enhancement. The hospital provides free parking and an excellent benefits package. Candidates should be NYS licensed, committedto patient care and interested in teaching. Diverse applicants, reflectingour multicultural patient and student population, is highly desirable. SUNY faculty appointments, research opportunities for appropriate candidates. Limited Permit and H-I visa sponsorship available.BE/BC Psychiatrists (will consider Limited Permit Psychiatrists) sought to lead psychiatric inpatient clinical team:

Interested applicants should apply to:
Kingsboro Psychiatric Center
Human Resources Management
681 Clarkson Avenue
Brooklyn, NY 11203
Fax (718) 221-7345
Email: Kingsboro.HR@omh.ny.gov

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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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.

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.

ELMIRA PSYCHIATRIC CENTER
Adult and Adolescent Psychiatrists
Board Eligible/Board Certified -
$148,421-$256,700
Limited Permit -Eligible applicants will also be considered

- All positions M-F 8-4:30
- Voluntary low stress on call at regular pay rate
- Student loan repayment available
- Excellent NYS benefits package
- Inpatient, Outpatient and Day Treatment services
- Our location offers: quality housing prices; little traffic; regional airport; Cornell University; 4hr drive to NYC, Toronto & Philadelphia; 5 ½ hr drive to Boston & DC; less than 1hr to Finger Lakes Wine Country; Watkins Glen International Racetrack.

For further info contact: Patricia Santulli, Director of Human Resources at: Elmira Psychiatric Center, 100 Washington Street, Elmira, NY 14901 or e-mail: P.Santulli@omh.ny.gov or call: (607) 737-4726 or fax: (607) 737-4722. An AA/EOE Employer

DID YOU KNOW?

In 1865, the Willard State Hospital (NY) opened with 1,000 beds for the first time rejecting the superintendents' policy that mental hospitals be no larger than 250 beds. By mid-20th Century, some state hospitals had over 10,000 beds.

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

NORTH CAROLINA

The **University of North Carolina (UNC) at Chapel Hill** offers a one-year ACGME-accredited fellowship in Psychosomatic Medicine (PM). Fellows conduct and supervise consultations in a wide variety of inpatient and outpatient settings between the General Psychiatry Consultation-Liaison Service and the Psycho-Oncology Service at UNC Hospitals. Fellows play a major role in teaching and are provided a robust educational program that includes at least 4 weekly conferences. Eligibility Requirements include: graduation from an ACGME-accredited Psychiatry Residency program; Step 3 of the USMLE Boards; and Eligibility for North Carolina medical licensure. Interested residents should email the program coordinator, Robin Haring at robin_haring@med.unc.edu, for more information.

CLASSIFIEDS

Psychiatrist

Monarch, a CABHA approved agency is currently recruiting for a full or part time Outpatient Psychiatrist in Charlotte, NC Monday - Friday 8AM to 5PM, No Call. Work with both adults & children, responsible for evaluating, diagnosing, and prescribing medications, will work along side Therapists with availability to refer patients to ACTT, TCM, CST, or IIHS services, provide education, ongoing monitoring, and involve/educate family members. Requirements: MD or DO degree, Board Certified or Board Eligible in Psychiatry, NC medical license (or obtain). Current NC Medicaid, Medicare, & private insurance provider (or willingness to obtain).

Please apply Online at www.MonarchNC.org Email Recruiter: Tory.Rule@MonarchNC.org EOE.

OHIO

CLEVELAND: Child and General Psychiatrists - Inpatient & Partial Programs. **TOLEDO:** General Psychiatrist - Inpatient and Rehab Programs. Fulltime or Part-time positions. Salary, benefits and bonus opportunity. Contact Will DeCuyper, In-house recruiter @ 866-227-5415 OR email will.decuyper@uhsinc.com.
MANSFIELD: Child Psychiatrist - Residential Treatment. Part-time. Flexible hours. Contact: Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

SOUTHERN OH - Beautiful area where the Scioto and Ohio Rivers meet; Portsmouth is close to Ashland, KY, under an hour to Huntington, WV and about 2 hours from Columbus and Cincinnati, Seeking an additional psychiatrist for outpatient work and sharing call on new geropsych unit. Salaried position w/benefits, or independent contractor arrangement may be a possibility as well. Join us at this exciting time on a new unit in an area with a great need for this service; & enjoy a fantastic, more laid back quality of life- an area loved by outdoor enthusiasts. Also need someone to help with 1 or 2 weekends per month. Please call Terry B. Good, Horizon Health, at 1-804-684-5661, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

OKLAHOMA

TULSA - Child Psychiatrist -Inpatient and Residential Treatment. Salary, benefits and bonus opportunity. Great staff teams and services. Minimal call. Contact Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

PENNSYLVANIA

PITTSBURGH Adult Outpatient Psychiatrist opportunity at Mercy Behavioral Health. Our financially solid organization with 25 psychiatrists offers competitive compensation with excellent benefits. Contact Jim Jacobson, MD at 412-488-4927 physician@mercybh.org.

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.

The Penn State Department of Psychiatry is recruiting psychiatrists for its growing faculty. With our clinical partner, Pennsylvania Psychiatric Institute, the Department staffs four clinics, with outpatient and partial hospital programs for children and adults, 58 adult and 16 child/adolescent beds, ECT and other neurostimulation services, and psychiatric consultation for 3 hospitals. Our current psychiatry faculty numbers 52, with planned increases, plus 24 residents and fellows. We have a growing research portfolio, with basic and clinical research and close collaboration with allied neuroscience disciplines at several Penn State campuses. We plan expansion in teaching programs as well. Positions in the following areas are available:

- Adult outpatient/partial
- Consultation Liaison
- Neuropsychiatry

Successful candidates should have strong clinical and teaching skills and, optimally, potential for scientific and scholarly achievement. Candidates with interest and skills in these areas should send a curriculum vitae and cover letter to:

Alan J. Gelenberg, M.D.
Shively-Tan Professor and Chair
Penn State Hershey Medical Center
Department of Psychiatry, H073
500 University Drive, P.O. Box 850
Hershey, PA 17033
Phone: 717.531.8516
Fax: 717.531.6491
agelenberg@hmc.psu.edu

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

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.

TENNESSEE

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

ADULT PSYCHIATRIST, CHILD PSYCHIATRIST, GERIATRIC PSYCHIATRIST

Three full-time positions available for Adult Psychiatrist, Child Psychiatrist and Geriatric Psychiatrist. The department seeks Adult Psychiatrist who is BE/BC (at time of hire), Child Psychiatrist who is BE/BC (at the time of hire) in the subspecialty of Child and Adolescent Psychiatry, and Geriatric Psychiatrist who is BE/BC (at the time of hire) in the subspecialty of geriatric psychiatry and will become involved in the development of a Geriatric Psychiatry Fellowship. Positions may include inpatient and/or outpatient. Program activities include clinical care of patients combined with teaching and supervision of residents and medical students. Adult or Child position may be considered for Director of Outpatient Clinic Programs. Research is encouraged but not essential. Salary and academic rank are commensurate with experience and qualifications. Salary is competitive with funding available through the Medical School, faculty private practice and extramural contracts. ETSU is located in Johnson City which is the perfect blend of four mild and beautiful seasons, gentle mountains and a symphony orchestra. Come explore this ideal family location of college/urban sophistication surrounded by national forests and serene pastures. No state income tax, low cost-of-living, low crime rate, lots of parks, golf courses, and lakes. Apply to this position at https://jobs.etsu.edu. Telephone inquiries should be made at (423) 439-2235 or e-mail at lovedayc@etsu.edu. AA/EOE.

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.

WASHINGTON

PSYCHIATRIST EASTERN STATE HOSPITAL MEDICAL LAKE, WA

ESH is recruiting for a psychiatrist. ESH is Joint Commission accredited and CMS certified. ESH is the 287 bed state psychiatric hospital in eastern WA 20 miles from Spokane. This position offers state employment with competitive benefits (including malpractice coverage) and opportunity for paid on-call duty. Join a stable Medical Staff of 30+ psychiatrists, physicians and physician assistants. Contact Shirley Maike, 509.565.4352, email maikeshi@dshs.wa.gov. PO Box 800, Medical Lake, WA 99022-0800.

WEST VIRGINIA

50 Minutes from Pittsburgh - Forbes' Top Ten "Best Places to Live Cheaply" because of the low cost of living, highly rated schools, low unemployment and low crime rate. Two Openings: Adult/Geropsychiatrist and Child/Adolescent/Adult Psychiatrist - Impressive general hospital offers a full continuum of psychiatric care. These are inpatient and outpatient positions; salaried with benefits and attractive bonus plan. Top-notch staff; great quality of life. Contact **Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; terry.good@horizon-

PROGRAMS AND SERVICES

Give An Hour (GAH) organization and the **American Psychiatric Foundation (APF)** have teamed to recruit mental health professionals to volunteer one hour each week for a minimum of one year to provide direct services in person, by phone or in consultation with schools and community organizations that serve the military community. Efforts are being made to create a large, national, volunteer network over the next three years to address postwar mental health issues such as posttraumatic stress disorder (PTSD),

CLASSIFIEDS

WISCONSIN

The Department of Psychiatry and Behavioral Medicine at the Medical College of Wisconsin (MCW) has initiated a national search to identify candidates for a new Chair, Psychiatry and Behavioral Medicine.

The Department is a dedicated community of compassionate, expert, inspired, professional clinicians, academicians, staff, and trainees committed to improving the lives of persons affected by psychiatric diseases, concurrent disorders, behavior-related illnesses, and social- environmental conditions impeding mental health. This mission is accomplished through the pursuit of six core values: (1) scholarship and research, (2) education, (3) clinical service, (4) community outreach, (5) bioethical principles, and (6) leadership and administration.The new Chair will develop and execute along with institutional leadership, a strategic plan, lead a comprehensive clinical service, lead a robust clinical research program designed to enhance translational research, and provide leadership that results in growth and enhanced excellence. The Chair will strive to strengthen and enhance the academic, research, and clinical excellence of the Department with recruitment, hiring, retention, development and support of outstanding faculty. Also, the Chair has the responsibility to manage all affiliate relationships and contracts (19 currently). The consolidated annual budget for the Department is approximately $25 million.

Please contact Jennifer Schaulin at (972) 768-5350 or via email at jennifers@millicansolutions.com for more details about the opportunity. The Medical College of Wisconsin is an EEO/AA Employer M/F/D/V.

Fellowships

PSYCHOSOMATIC MEDICINE/ CONSULTATION-LIAISON PSYCHIATRY COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS AND SURGEONS

The Department of Psychiatry at Columbia University College of Physicians and Surgeons offers a one-year fellowship in Psychosomatic Medicine at New York Presbyterian Hospital-Columbia University Medical Center, for board eligible/board certified graduates of approved psychiatric residency programs. The fellowship seeks psychiatrists with outstanding clinical and academic records as evidenced by publications, presentations, teaching experience, and exceptional letters of recommendation, who are interested in an academic career in Psychosomatic Medicine (consultation-liaison psychiatry). Spanish speaking a plus. This is a full-time, ACGME-approved program with clinical, research, and teaching experience at a major tertiary care center. Some call is required. Applicants are sought for the 2013-2014 academic year.

To apply, please submit, by email or U.S. Postal Service, a personal statement, three letters of recommendation, and a C.V., no later than October 15, 2012. For further information applicants should contact Ms. Marna Freed at Columbia University, College of Physicians and Surgeons, 622 West 168th Street, PH-16, New York, NY 10032; (212) 305-9985, or by email at mf251@columbia.edu. Columbia University is an AAEOE.

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**. Under the guidance of Dr. Thomas Wise and Dr. Catherine Crone, the fellowship offers consultation-liaison training in a wide variety of medical specialties in both inpatient and outpatient settings. This includes: oncology, ob/gyn, HIV, trauma, organ transplantation, pulmonary medicine, and cardiology. Didactic seminars address clinical, biological, cognitive behavioral and psychodynamic approaches the understanding and treating the medically ill. Opportunities in teaching, research, and outpatient psychotherapy are readily available. Training is tailored to fellow's area of interest and career goals. The fellowship is based at Inova Fairfax Hospital, an 833-bed tertiary care teaching facility located in the heart of the DC Metro area.

Interested individuals should contact:
Catherine Crone, M.D.
PM Fellowship Program Director
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Medical Center
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22042
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FELLOWSHIP PUBLIC PSYCHIATRY at YALE

Yale School of Medicine is accepting applications for a one-year Fellowship in Public Psychiatry for July 2013, for individuals interested in developing leadership skills in public mental health and administration. We are now offering 3 positions at the level of Instructor in the Yale Department of Psychiatry. The fellows will spend 50% time engaged in seminars and other academic activities at the CT Mental Health Center (CMHC), a state funded community mental health center at Yale University in New Haven. One fellow will spend 50% time in clinical activities at CMHC and 2 fellows will spend their 50% clinical time at CT Valley Hospital in Middletown. Salary will be at the level of a junior faculty member. All candidates must be eligible for board certification and CT licensure. Minority applicants are encouraged to apply.

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