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PSYCHIATRIC NEWS

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James H. Scully Jr., M.D., has steered the Association through challenging as well as exciting times during his tenure as APA medical director and CEO. A search committee headed by former APA President Paul Appelbaum, M.D., is now seeking potential candidates to succeed him. See article below.

Scully to Retire After Whirlwind Decade

James H. Scully Jr., M.D., will retire as APA medical director and chief executive officer at the end of this year after a decade of remarkable change and progress.

BY MARK MORAN

A lot can happen in 11 years.

But what's happened in the period since James H. Scully Jr., M.D., became medical director and CEO of APA might fill a couple of curricula vitae: a realignment of APA's organizational structure and a strengthening of its financial position; a new emphasis on transparency, particularly with regard to the Association's relationship with the pharmaceutical industry; the adoption of new technologies that have transported APA's publishing activities and member services into the 21st century; and—most recently—the finalization of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders,* which will serve as the diagnostic guidebook for a new generation of psychiatrists and other mental health professionals.

And outside of APA's walls—but with crucial advocacy on the part of Scully, the Board of Trustees, and staff in the Division of Advocacy—the medical director's tenure has also seen landmark legislative achievements: the passage of mental health parity and an end to discriminatory reimbursement policies in Medicare.

And now he plans to leave APA at the end of 2013. A search committee has been appointed to identify possible successors.

From the beginning, Scully was guided by a singular vision that he outlined in an interview with *Psychiatric News* in 2002, immediately after his appointment: to make APA "the premiere medical specialty organization" in the United States.

Today he says that original vision is what continued to inspire him throughout a tumultuous decade. "Whether we've achieved it or not, other people will

see ***Scully*** *on page 22*

Choline May Protect Infants From Developing Schizophrenia

Neonatal dietary supplementation with choline may enhance development of cerebral inhibition, which is related to sensory gating and attention.

BY MARK MORAN

Perinatal supplementation with dietary choline appears to activate neonatal cerebral inhibition—a critical developmental function in the brain related to sensory gating and attention—even in the presence of gene mutations that otherwise delay it.

A study appearing online in *AJP in Advance* on January 15 showed that amniotic choline activates fetal a7-nicotinic acetylcholine receptors and facilitates development of cerebral inhibition, possibly protecting infants from schizophrenia and other severe mental illness in which deficiencies of sensory gating and attention are prominent.

In the study, 100 pregnant women were randomized in their second trimester to receive a dietary supplement of phosphatidylcholine (n=46) or placebo (n=47). (Seven women dropped out of the study.)

Neonatal cerebral inhibition was tested using an electrophysiological recording of P50 evoked response to paired sounds. The primary outcome measure was the P50 inhibition ratio—that is, the amplitude of the P50 response to the second of paired auditory stimuli divided by the amplitude of the response

see ***Choline*** *on page 23*

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

Florida judge helps educate his colleagues about mentally ill defendants.

Imaging helps predict anxiety disorder patients who may benefit from CBT.

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 | 120mg

INDICATIONS AND USAGE

LATUDA is an atypical antipsychotic agent 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.

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- **LATUDA is not approved for the treatment of patients with dementia-related psychosis.**

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. May 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 Warnings and Precautions (5.1)]*.**
- **LATUDA is not approved for use in patients with dementia-related psychosis *[see Warnings and Precautions 5.1)]*.**

1 INDICATIONS AND USAGE

LATUDA is indicated for the treatment of patients with schizophrenia.

The efficacy of LATUDA in schizophrenia was established in five 6-week controlled studies of adult patients with schizophrenia *[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% (26/260)	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	–13.4	–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 4. 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 5.

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% (0/708)]. 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 0.1% (2/1508) of patients treated with LATUDA compared to 0.1% (1/708) 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 Reactions 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	4
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 7.

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**	**23**	**39**	**20**
All EPS events, excluding Akathisia/ Restlessness	**6**	**6**	**11**	**12**	**22**	**13**
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).

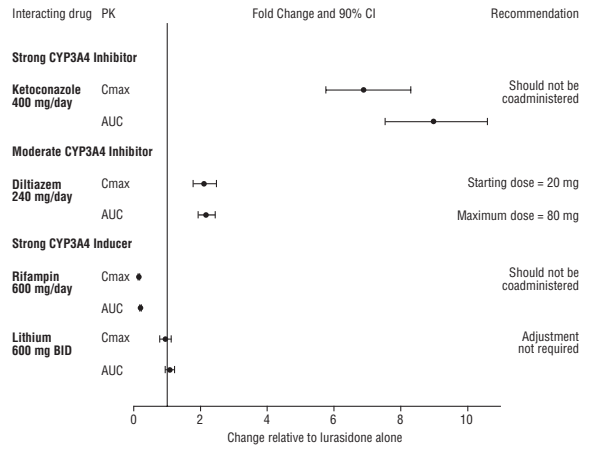
Blood and Lymphatic System Disorders: ***Infrequent:*** *anemia*
Cardiac Disorders: ***Frequent:*** *tachycardia;* ***Infrequent:*** *AV block 1st degree, angina pectoris, bradycardia*
Ear and Labyrinth Disorders: ***Infrequent:*** *vertigo*
Eye Disorders: ***Frequent:*** *blurred vision*
Gastrointestinal 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).

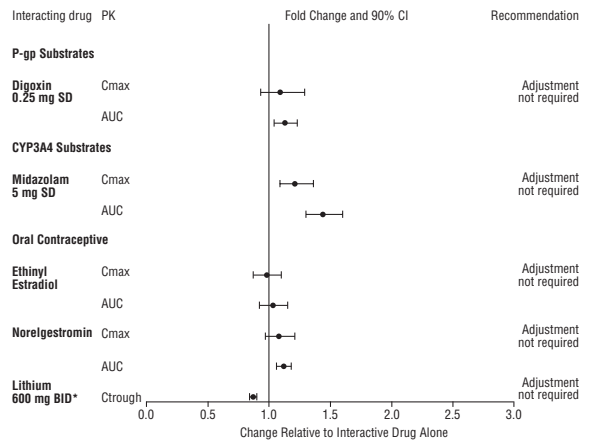
Figure 1: Impact of Other Drugs on LATUDA Pharmacokinetics



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.

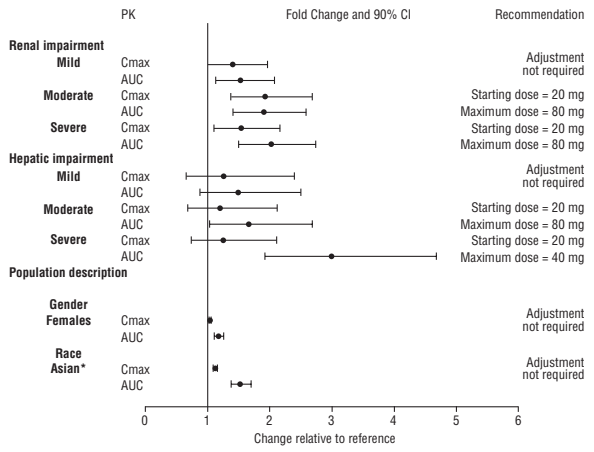
8.4 Pediatric Use
Safety and effectiveness in pediatric patients have not been established.

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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KEYNOTE SPEECH

President Bill Clinton
Founder of the William J. Clinton Foundation and 42nd President of the United States
Monday, May 20
5:30 p.m. – 6:30 p.m.

GENERAL INFORMATION

CME CREDIT – SCIENTIFIC PROGRAM

NOTE: THIS ACTIVITY HAS BEEN APPROVED FOR *AMA PRA Category 1 Credit(s)™*. The overall scientific program provides a broad range of presentations, which include regular courses and master courses, scientific and clinical reports, seminars, symposia, and workshops, plus many other sessions. For further information, please refer to the *Tentative Program Schedule* on APA's website and review the CME information in the final *Program Guide* onsite. A more complete program will be printed in the February 15, 2013 issue of *Psychiatric News*.

The APA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The APA designates this live activity for a maximum of 50 *AMA PRA Category 1 Credits*.™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.

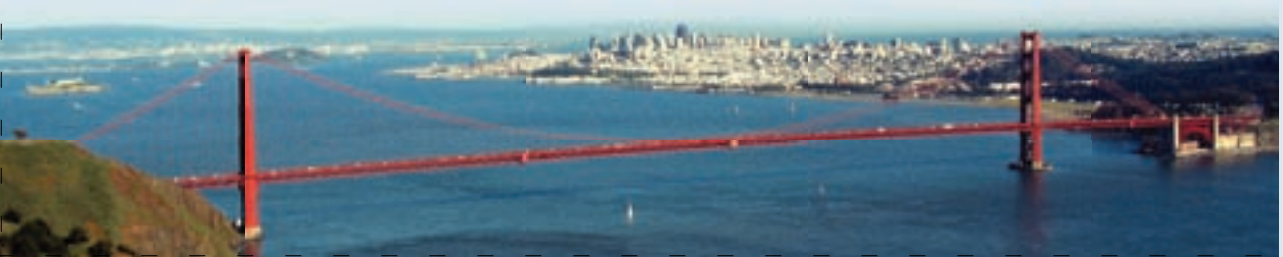
EDUCATIONAL OBJECTIVES

At the conclusion of this meeting, participants will be able to:

- Review new research findings in the fields of psychiatry and neuroscience and address gaps in knowledge
- Acquire new knowledge and skills in clinical psychiatry to improve patient care
- Identify and remove barriers to the transfer of new knowledge for your practice, and provide culturally competent care for diverse populations
- Assess a variety of treatment choices, including psychotherapeutic and pharmacological options
- Recognize health service delivery issues, including barriers to care

COURSES

Offered in four-hour (half-day), six-hour (full-day), and eight-hour (full-day) sessions, courses either review basic concepts in a special subject area or present advanced material on a circumscribed topic. These sessions are in addition to your meeting registration. See Registration and Course Enrollment for more details.



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Commercial and educational exhibits will be located in the Exhibit Hall, along with the Publisher's Book Fair, Career Fair, APA Member Center, Health Pavilion, coffee lounges, and food court. For your convenience, the Publisher's Book Fair, Career Fair, International Meetings Pavilion, and APA Member Center will be open Saturday, May 18, 9:00 a.m.-4:00 p.m. Educational and commercial exhibit hours are: Sunday, Monday, and Tuesday, May 19-21, 10:00 a.m.-4:00 p.m. daily.

SHUTTLE BUS SERVICE

Service will begin on Saturday, May 18, at 7:00 a.m., and will operate daily throughout the meeting commensurate with the scientific program schedule. It will conclude on Wednesday, May 22, at 5:30 p.m. The Moscone Convention Center will serve as the "hub" for all shuttle bus routes.

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If you have a disability and require special materials or services during the meeting, attach a brief statement describing your needs on the registration form.

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The list below will assist you in directing your questions to the appropriate office. You may write to the offices listed below in care of the APA, call toll free 1-888-35-PSYCH, or call 703-907-(see individual extensions below). For a full list of services and staff responsibilities, go to: http://annualmeeting.psychiatry.org/

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Exhibits: x7382
Registration: x7300
Request for Meeting Space: x7375

Office of Scientific Programs
Scientific Program: x7808
Courses: x8530

Administrative Services
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Advance Meeting Information Online:
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Department of CME
CME Credit: x8661

American Psychiatric Foundation
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2013 dues must be paid to qualify for the member rate. Contact the APA Membership Office at 703-907-7300 or 888-357-7924 with questions regarding your membership status before registering for the meeting.

	STANDARD REGISTRATION PACKAGE		GOLD REGISTRATION PACKAGE	
	Advance Jan. 25-Apr. 19	*Onsite* Apr. 20-May 22	*Advance* Jan. 25-Apr. 19	*Onsite* Apr. 20-May 22
Full Program	$415	$455	$814	$854
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Take advantage of member pricing if your membership application and registration form is received by March 15, 2013. A membership application must be submitted with your Annual Meeting registration form.

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Full Program	$1,000	$1,100	$1,399	$1,499
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Daily	$535	$570	$934	$969
Medical Students*	$0	$0	$199	$199
Presenters (M.D.)	$660	$725	$1,059	$1,124
Spouse/Significant Other	$230	$255	$629	$654

* Verification required

**Spouse or significant other live in the same household, is not an APA member, and receives mail at the same address. This cannot be used for a colleague, APA member, siblings, or children. Only one additional registration is allowed per full program registrant. Identification will be checked onsite. Registered spouse/significant other attendees can attend all sessions (except Member Only), visit the exhibit hall, and use shuttle bus transportation.

NOTE: Complimentary registrations are honored for Course Directors/Faculty and District Branch Executive Staff (who are not APA members).

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Courses are designed to emphasize learning experiences that actively involve participants and include the opportunity for informal exchange with the faculty. Attendees must be registered for the annual meeting and purchase tickets to attend courses.

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Full Day (8 hours)	$300	$340
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NOTE: Mailed and faxed registrations are assessed an additional $10 and will not be accepted after April 19, 2013. **Register online and save!**

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PAYMENT

The APA only accepts VISA, MasterCard, American Express, money order, or a check (in U.S. funds only), payable to the American Psychiatric Association. APA **does not** accept bank or wire transfers. Registrations will not be processed without proper payment.

CONFIRMATION

If you do not receive registration and/or course enrollment confirmation within three weeks of sending your form, contact the APA office at 703-907-7810 or registration@psych.org.

PROVISIONAL REGISTRATIONS

Nonmember medical student, non-medical student, advocacy group member, mental health chaplain, psychiatric resident and fellow registrations are considered provisional until status verification is received. To qualify for the fee reduction or exemption, a copy of your valid student ID or letter from advocate/chaplain institution or residency program director **must be received within seven (7) days** of your online registration or included with your mailed or faxed registration. If your verification is not received within this time period, the registration will be cancelled.

CANCELLATION FEES & REFUNDS

All registration and/or course cancellation requests must be received in writing by the APA Office fax: 703-907-1097 or email: registration@psych.org by May 8, 2013. A confirmation will be sent once the request has been processed. The fee will be refunded in the manner in which it was received. Refund policy and cancellation fees are as follows:

Until March 15, 2013	Full refund
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Onsite registration will take place at the Moscone Convention Center.

Friday, May 17, 2013
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12 noon – 6:00 p.m.

Saturday, May 18, 2013 – Tuesday, May 21, 2013
7:30 a.m. – 5:00 p.m.

Wednesday, May 22 , 2013
7:30 a.m. – 10:30 a.m.

INTERNATIONAL TRAVEL INFORMATION

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Begin the visa application process immediately. The visa process takes longer than you may anticipate. For further information, visit the Department of Homeland Security website at https://esta.cbp.dhs.gov.

International travelers who are seeking to travel to the United States under the Visa Waiver Program (VWP) are subject to enhanced security requirements. All eligible travelers who wish to travel under the Visa Waiver Program must apply for authorization through the Electronic System for Travel Authorization (ESTA). The VWP is administered by the Department of Homeland Security (DHS) and enables citizens and eligible nationals of certain countries to travel to the United States for tourism or business for stays of 90 days or less without obtaining a visa.

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To receive an invitation letter from the APA (for registered attendees only), write the APA Registration Office at registration@psych.org and include your full name, complete mailing address and Annual Meeting registration badge number. Invitation letters will be sent via email in the PDF format. Please allow 10 business days for receipt of your invitation letter.

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May 18-22, 2013 • San Francisco, CA

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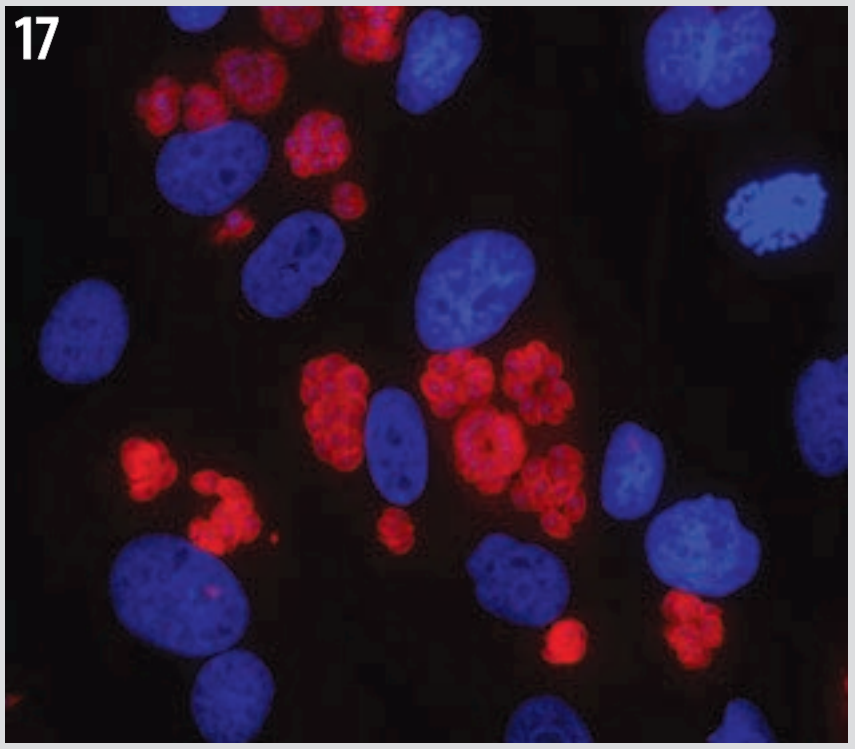

COMMUNITY NEWS

PROFESSIONAL NEWS

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CLINICAL & RESEARCH NEWS

Be the First to Get *DSM-5*

Attendees of APA's 2013 annual meeting in San Francisco will have an exclusive opportunity to purchase *DSM-5* before it goes on sale to the public on May 22. Also, if you register now, you can take advantage of advance registration fees. To register, go to http://annualmeeting.psychiatry.org; you will need your log-in information to receive member rates. (If you do not have this information, call [703] 907-7300.) To receive the best hotel rates, contact Travel Planners, the official APA housing bureau, at (800) 221-3531 or (212) 532-1660.

Departments

Child/Adolescent Fellowship Opens Many Career Doors

For a decade, psychiatry residents have harvested substantial career benefits from the fellowship APA offers in child and adolescent psychiatry.

BY JOAN AREHART-TREICHEL

For a decade now, APA has conducted a fellowship program to help advance the careers of psychiatrists interested in child and adolescent psychiatry.

Cathryn Galanter, M.D., a visiting associate professor of psychiatry and director of the Child and Adolescent Psychiatry Training Program at New York's SUNY Downstate Medical Center in Brooklyn is, as she puts it, the "proud founder" of the program.

"When I was a child and adolescent psychiatry fellow, I saw the need for a fellowship to engage general psychiatry residents in child psychiatry, as children's mental health was, and still is, greatly underserved," she explained. "We first proposed the idea of the fellowship to the APA Council on Children, Adolescents, and Their Families. They were very supportive of the idea, but not able to secure funding. Our next step was to write an action paper and present it to the APA Assembly. The action paper stated the importance of the fellowship and requested that APA look into funding the program. The action paper was approved. Soon after, funding was secured."

The two-year fellowship, open to PGY-1 through PGY-3 APA members, is financed by an unrestricted educational grant from Shire Pharmaceuticals. During the first year, fellows attend the APA annual meeting as participants, meet individually with their mentors, get together as a group with other fellows, and attend sessions focused on child and adolescent psychiatry. After the annual meeting, each fellow develops, with the help of his or her mentor, a proposal for a symposium or workshop at the next APA annual meeting.

During the second year, if their proposals are accepted, the fellows present their symposia or workshops. They are also encouraged to attend the meetings of the APA Council on Children, Adolescents, and Their Families, which offers them networking and mentoring opportunities and exposes them to development of policy that will affect the practice of psychiatry and especially treatment of mentally ill youth.

One of the fellows selected for 2012-2013 is Erica Greenberg, M.D., a PGY-3 at Harvard University. "I've had a long-standing interest in child and adolescent psychiatry, and the fellowship seemed like the perfect opportunity to increase my direct involvement with the child and adolescent psychiatry community," Greenberg told *Psychiatric News*.

Another of the fellows selected for 2012-2013 is Dawn Sung, M.D., a PGY-3 at New York University. "I applied for the fellowship because of my interest in child and adolescent psychiatry and a desire to become more involved with APA as a trainee," she said. "I also have a special interest in cultural issues, given my own background as a second-generation Korean American. . . . It has been a great experience to not only attend the APA annual meeting and meet other residents with similar interests, but also to be paired with a mentor, Dr. Andres Pumariega, who has accomplished a great deal with cultural issues pertaining to child and adolescent psychiatry. With his support and mentorship, I have been able to submit a proposal for a workshop for the 2013 APA annual meeting addressing intergenerational conflict within immigrant families."

Mikel Matto, M.D., a PGY-2 at the University of California, San Francisco, is another fellow chosen for 2012-2013. "The beauty of the fellowship," he said, "is that… even with my fairly specific research goals, I was able to be linked to a wonderful mentor, Dr. Alice Mao, who was able to further this interest. I had the opportunity to help develop a proposal for a workshop at next year's APA annual meeting…that combined Dr. Mao's expertise in autism with my research in the use of technology as a treatment modality."

Yet a fourth fellow selected for 2012-2013 is Jacqueline Landess, M.D., a PGY-3 at Northwestern University, who said, "I've been networking with a group of psychiatrists to develop a symposium for the next APA annual meeting that would focus on issues related to differential diagnosis in those with developmental and intellectual disabilities."

Current fellow Sarah Richards Kim, M.D., of Columbia University, attended the 2012 APA annual meeting and connected with other residents interested in child psychiatry. She and her mentor had a workshop on creating a symposium proposal for this year's annual meeting PN

Information about the fellowship is available from Alison Bondurant by phone at (703) 907-8639 or e-mail at abondurant@psych.org. To view a video interview with Galanter about the fellowship, go to http://www.youtube.com/watch?v=1byKmcsyJCw.

COMMUNITY NEWS

Newtown Organizes MH Services For the Long Term

Mental health providers in Newtown, Conn., collaborate to plan long-term care for townspeople after December's deadly school shooting.

BY AARON LEVIN

The big St. Bernard lay on the floor in the hallway, waiting to have its belly rubbed.

True, St. Bernards aren't part of the standard psychiatry residency, but this one and 14 other canines of varying breeds joined the resources gathered in the family assistance center set up in Newtown, Conn., after the shooting rampage last December that left 20 children and seven adults dead.

A therapy-dog organization brought the St. Bernard and friends, Save the Children set up an arts-and-crafts room, and three mental health organizations provided more-conventional care at the Reed Intermediate School in Newtown.

Wellmore, a mental health services organization with expertise in mobile crisis services; Danbury Hospital; and Family and Children's Aid (FCA) collaborated on operating a site to which people affected by the tragedy could go for therapy or just a sympathetic ear, said FCA's executive and medical director, Irvin Jennings, M.D.

"What evolved was a wonderful model," Jennings told *Psychiatric News*. "It was part grief counseling and part kids' play area."

Each organization had staff members there every day for the following week, with FCA doing administrative work (like vetting the credentials of volunteer counselors) as well as providing clinical services. The dogs "just showed up," said Jennings. Kids could pet the dogs or do art projects while their parents talked with counselors. The center logged at least 1,350 encounters in its first 10 days of operation.

Irvin Jennings, M.D.

Irvin Jennings, M.D., supervises Mikey the Therapy Dog at the Reed Intermediate School in Newtown, Conn., after the shooting at Sandy Hook Elementary School in December.

Even the dogs played well together, he said.

Eventually, a collection of town and state agencies, along with representatives from the school district and local government, coalesced with the three groups running the crisis center into a coordinating council, said Charles Herrick, M.D., chief of psychiatry at Danbury Hospital. The council is now assessing community needs and organizing the transition to longer-term services

"We hope to establish some kind of ongoing drop-in center to provide information and have clinicians available to do screening and refer as needed," said Herrick in an interview. "Our plan is to build capacity with trained clinicians."

The council will start by creating a list of three sets of clinicians: those who are already seeing affected children and families, those with specific training in trauma-focused care, and those who will need training in such care.

Psychologist Stephen Marans, Ph.D.,

see ***Newtown*** *on page 13*

Disaster Psychiatrist Fills Niche In School-Shooting Aftermath

An experienced emergency psychiatrist helps residents of Newtown, Conn., cope with the aftermath of the mass murders at Sandy Hook Elementary School.

BY AARON LEVIN

"I've worked with survivors of disasters from 9/11 on, but this was the toughest thing I've ever done," said Anthony Ng, M.D., after returning home to Maine from five days helping out in Newtown, Conn., after the December 14, 2012, shooting at Sandy Hook Elementary School.

On ordinary days, Ng is the chief medical officer at Acadia Hospital in Bangor, Maine, and chief of the psychiatry service at Eastern Maine Medical Center in Bangor. He has also served on APA's Committee on the Psychiatric Dimensions of Disasters.

Within a day of the tragedy, Ng got a call from Rob Yin, L.I.S.W., manager of the disaster mental health program for the American Red Cross, asking him to go to Newtown. Besides his long experience helping people cope with the psychological aftermath of disasters, Ng previously worked closely with the Red Cross and knew how the organization manages the mental health side of its response.

"You need to be trained and prepared for disasters," Ng told *Psychiatric News*.

Ng arrived in Newtown on the Sunday following the shooting and worked with family members of victims at a center set up in a local mental health clinic. (Other people in need of counseling were seen by Connecticut Psychiatric Society members and others working with the Red Cross at the Reed Middle School [*Psychiatric News*, January 4].)

At one point, Ng met with the father of a boy who was killed in the attack. What the man needed, however, was not sophisticated psychiatry.

Anthony Ng, M.D.

Disaster psychiatry specialist Anthony Ng, M.D.: "No amount of medical school or psychiatric training prepares you to see this."

"Just simple things," said Ng. "Support, psychological first aid, simply being there." The man talked a lot about his son. At one point he pulled out photographs of the boy.

"I want you guys to see how he looked," he said.

"I'm a parent, and so this really hit home," said Ng.

The man did not seem to have a lot of outside support. On learning that the man didn't have a suit to wear to his son's funeral, Ng and someone from the FBI's Victims Assistance Program took him to a store to buy one. Later, the man also asked Ng and a Red Cross worker to go with him to the funeral.

"No amount of medical school or psychiatric training prepares you to see this," said Ng. "The whole town was suffering though funerals, memorials, and wakes."

Ng is concerned about the future of the people he saw in Newtown, and not just regarding clinical issues. The well-intended donations or possible financial settlements that come in the wake of tragedies may create new problems, as became apparent after the Exxon Valdez and BP oil spills, he said.

Deciding which recipients or aid agencies should or should not get funds and how much each receives can be a messy process. "In my experience with other big disasters, the sudden surge of financial donations in support of the response and recovery efforts can easily generate a lot of tension," said Ng. "So it is important that psychiatric leadership be aware and even be involved in the postdisaster financial response, too." PN

PROFESSIONAL NEWS

DSM-5 Fine-Tunes Diagnostic Criteria For Psychosis, Bipolar Disorders

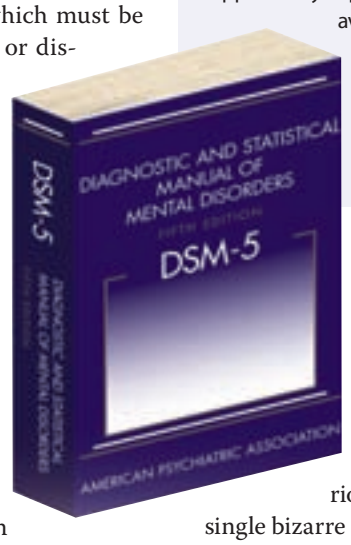
Changes to *DSM-5* criteria for psychosis and bipolar disorder are intended to make criteria more accurately reflect the way patients present. This is the second article in a series summarizing the major changes to diagnostic criteria in *DSM-5* between now and its publication date in May.

BY MARK MORAN

An anxious distress "specifier" will be delineated in the *DSM-5* criteria for bipolar disorder—as well as for depressive disorders—as a step toward a dimensional rating of a feature that significantly affects treatment outcome for a variety of disorders.

Additionally, criteria for bipolar disorder will now include an emphasis on changes in activity and energy—not just mood—to reflect findings from recent research. And the new manual eliminates the diagnosis known in *DSM-IV* as "bipiolar disorder 1—mixed type" and instead includes a "mixed state" specifier that can be used when episodes of mania include depressive symptoms and for depression that includes mania or hypomania.

Meanwhile, changes to criteria for schizophrenia include elimination of the subtypes delineated in previous editions and the creation of a catatonia specifier—as opposed to a separate subtype of psychosis—that can be used for depressive, bipolar, and psychotic disorders, or as a separate diagnosis in the context of a known medical condition. Additionally, two Criterion A symptoms will be required for any diagnosis of schizophrenia, at least one of which must be delusions, hallucinations, or disorganized thinking—the core "positive symptoms" that are necessary for a reliable diagnosis of schizophrenia.



But the most dramatic proposed changes to the chapter on psychotic disorders—the addition of dimensional ratings of severity and the inclusion of a new attenuated psychosis syndrome (APS)—were not approved for inclusion in the main text of diagnoses but placed in Section 3, where it is hoped they will attract research interest to guide future clinical utility.

Changes Called Mostly Conceptual

The *DSM-5* chapters on psychotic and bipolar disorders are the second and third chapters in Section 2 of the new manual; they appear in succession as part of a new organizational schema designed to link disorders that share common genetic or neurobiological substrates (*Psychiatric News*, January 18). The multiple "axes" of previous editions have been eliminated, and a developmental approach guides the placement of disorders—those common to childhood appear at the beginning of Section 2, while those more typical of late life appear at the end.

In an interview with *Psychiatric News*, William Carpenter, M.D., chair of the Psychotic Disorders Work Group, said the major changes to the chapter on psychotic disorders are unlikely to affect case prevalence, but reflect conceptual changes that should make the criteria more accurately reflect individual patient presentation.

Perhaps most prominently, clinicians will note that the subtypes listed in *DSM-IV*—catatonic, disorganized, paranoid, residual, and undifferentiated—have been eliminated. "The main reason is that they have not proven useful clinically and are not a good heuristic for understanding psychosis," Carpenter said.

He added, "It's a mistake to think of catatonia as a subtype of schizophrenia, and the subtypes have tended to reinforce that mistake." Instead, catatonia is listed as a specifier throughout *DSM-5*. A second important conceptual change from *DSM-IV* is that a patient can no longer meet Criterion A for psychosis with a single bizarre delusion, but must have a minimum of two symptoms—one of which must be one of the core psychotic symptoms of "delusions, hallucinations, or disorganized thinking."

"It's an important conceptual change because it's a mistake to give that primacy to a single bizarre delusion, but we don't think it will make a difference in caseness because it almost never happens in nature," he said.

In a related change, Criterion A for delusional disorder no longer has the requirement that the delusions must be nonbizarre. However, specifiers for bizarre and nonbizarre delusions provide continuity with *DSM-IV,* Carpenter said.

A very important proposed change by the Psychotic Disorders Work Group was the inclusion of dimensional ratings that would have allowed clinicians to rate symptoms on a severity scale of 0 to 5. "It's an idea based on a lot of research around 'deconstructing' schizophrenia, and nearly everyone agrees this is sensible," Carpenter said.

However, the dimensional ratings were placed in Section 3 because of concerns that clinicians would find the ratings burdensome and inadequately tested for added value in routine clinical practice. But Carpenter said clinicians who want to use the dimensional ratings in Section 3 can do so, and he added that he hopes their inclusion there will introduce clinicians to the concept.

Finally, another controversial proposal didn't make it into the main text and will also appear in Section 3—the diagnosis of attenuated psychosis syndrome, to describe individuals experiencing distress from attenuated symptoms that fall short of the clinical threshold for psychosis.

"That's a good candidate for Section 3 because a lot of people think it needs more research," Carpenter said. "And there are legitimate questions about whether the criteria can be reliably used by nonexperts. But clearly earlier identification of patients is the wave of the future and the inclusion of the criteria in Section 3 provides a path forward."

Anxiety Predicts Treatment Response

Probably the most prominent change clinicians will notice in criteria for bipolar disorder is the removal of the "mixed type" diagnosis and its replacement with a "mixed state" specifier that can be used across the mood disorders. "It can be used for mania when there are depressive symptoms and for depression when there are manic symptoms," Jan Fawcett, M.D., chair of the Mood Disorders Work Group, told *Psychiatric News*.

He added that he hopes clinicians will make use of the specifier since the presence of mixed states is frequent across the mood disorders. "We want it to be used as specifier more, not less," he said.

Another change from *DSM-IV* is an emphasis on bipolar disorder as a disorder not only of mood but of energy. "We don't think this will change the frequency of diagnosis, but it will make the criteria more accurate," Fawcett said. "Evidence has been accumulating, especially from work in Switzerland by Jules Angst, that bipolar isn't just a mood disorder, but a disorder of mood, energy, and activity."

Also, criteria have been removed stating that a diagnosis of bipolar dis-

see **DSM-5** *on facing page*

Key Points

These are among the major changes in the *DSM-5* chapters on schizophrenia spectrum and other psychotic disorders and on bipolar and related disorders:

- Schizophrenia "subtypes" listed in *DSM-IV* have been eliminated.
- Catatonia is now a specifier that can be used for a variety of disorders.
- Criterion A for psychosis now requires the presence of at least two symptoms—as opposed to one—and one of those symptoms must be the core psychotic symptoms of delusions, hallucinations, or disorganized thinking.
- Dimensional ratings of severity and criteria for attenuated psychosis syndrome are placed in Section 3 for further research.
- "Mixed type" bipolar disorder is eliminated and replaced with a "mixed state" specifier that can be used when manic symptoms accompany depression or when depressive symptoms co-occur with mania.
- The new criteria emphasize that bipolar disorder is a disorder of mood, energy, and activity.
- An "anxious distress specifier" has been included for use across all bipolar and depressive disorders, with severity ratings appearing in Section 3.

Preorder Your *DSM-5* Now!

DSM-5 may be preordered at http://www.appi.org/SearchCenter/Pages/default.aspx?k=2555. Also, attendees at the 2013 annual meeting in May will have an exclusive opportunity to purchase *DSM-5* before it goes on sale to the public. The manual will be available in the American Psychiatric Publishing Bookstore in the Exhibit Hall in the Moscone Convention Center. Those who come to the bookstore on Saturday, May 18, from 4 p.m. to 5 p.m., can meet the *DSM-5* Task Force chairs and receive a free gift with purchase. (See the box on page 7 for meeting registration information.) Whether buying online or in person, APA members are eligible for a discount.

VIEWPOINTS

How APA Keeps Bias Out of Practice Guidelines

BY JOEL YAGER, M.D., AND LAURA FOCHTMANN, M.D.

A recent *Washington Post* series titled "Can Medical Research Be Trusted?" specifically mentioned APA's *DSM-5* Mood Disorder Work Group and the work group that developed APA's Practice Guideline for the Treatment of Patients With Major Depressive Disorder (third revision, 2010) in discussing various types of industry ties (http://www.washingtonpost.com/business/economy/antidepressants-to-treat-grief-psychiatry-panelists-with-ties-to-drug-industry-say-yes/2012/12/26/ca09cde6-3d60-11e2-ae43-cf491b837f7b_story.html; http://www.washingtonpost.com/business/economy/defining-depression/2012/12/26/bbbf6b24-4fc6-11e2-950a-7863a013264b_graphic.html).

Graphics indicating the number and types of ties disclosed by individually named group members depicted each person's industry-related grant support, research funding, lecture fees, advisory board memberships and other relationships with industry. The article implies that these industry relationships may have influenced the changes that have been made in the *DSM-5* diagnosis of major depressive disorder and may increase use of antidepressant treatment among bereaved individuals. In this context, we thought it would be helpful to discuss the process by which we developed the Practice Guideline for the Treatment of Patients With Major Depressive Disorder and the changes that are being introduced into APA's practice guideline development process.

When the third revision of the major depressive disorder guideline was initiated in 2005, there was increasing dialogue at a national level about the potential role of industry influences on clinical practice and recommendations made by clinical guidelines. Work group members disclosed conflicts as part of the group's deliberations. The work group and APA's Steering Committee on Practice Guidelines were aware that industry relationships or individual viewpoints might color recommendations and worked hard to assure that final recommendations were free of such effects and based solely on a careful appraisal of available evidence. By the time the development process had been completed and the major depressive disorder guideline was being readied for publication, there was heightened attention to the potential effects of industry relationships, in part related to the publication of the Institute of Medicine report in 2009 on Conflict of Interest in Medical Research, Education, and Practice. In light of this evolving landscape on conflict-of-interest considerations, the APA Steering Committee on Practice Guidelines took the additional step of appointing a group of well-regarded research and clinical experts in mood disorders to review the guideline recommendations for evidence of industry bias. This independent review committee of experts who had zero industry ties found no evidence for any industry influence in the recommendations.

The treatment recommendations themselves suggest that industry bias was not an issue. The guideline gives equal weight to psychotherapy and antidepressant medications for treating moderate levels of major depression. And, the first-line medications that are recommended for use in major depression include nonproprietary agents whose patents have expired and are available in generic formulations. With bereaved individuals, the guideline notes that normal grief is distinct from major depressive disorder and "should be treated with support and psychoeducation about symptoms and the course of mourning." However, like other psychosocial stressors, bereavement can trigger a major depressive episode. It is under such circumstances that the guideline recommends treatment "with medication and/or depression-focused psychotherapy." Between these options, the guideline notes that selecting an initial treatment for major depressive disorder "is influenced by several factors, including the symptom profile, the presence of co-occurring disorders or psychosocial stressors, the patient's prior treatment experience, and the patient's preference."

Since publication of the major depression guideline in 2010, the national views on conflicts of interest and practice guidelines have undergone even more changes. In 2011 the Institute of Medicine published two landmark reports, "Standards for Developing Trustworthy Clinical Practice Guidelines" (http://www.iom.edu/Reports/2011/Clinical Practice-Guidelines-We-Can-Trust/Standards.aspx) and Finding "What Works in Health Care: Standards for Systematic Reviews" (http://www.iom.edu/Reports/2011/Finding-What-Works-in-Health-Care-Standards-for-Systematic-Reviews.aspx), designed to provide guidance and standards for professional associations and other guideline-writing groups. The recommendations of these reports are aimed at maximizing the "trustworthiness" of practice guidelines and minimizing the potential impact of industry influences on guideline treatment recommendations. Among several dozen specific recommendations, the IOM guidance advises that expert members of a guideline-writing group might in fact have industry ties, but that such ties must be carefully managed. According to IOM standards, individuals with industry ties must constitute less than 50 percent of the members of a guideline-writing

*see **Viewpoints** on page 20*

Joel Yager, M.D., is chair of APA's Steering Committee on Practice Guidelines. Laura Fochtmann, M.D., is medical editor of the practice guidelines.

DSM-5

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order could not be made if the patient became manic while on antidepressant medication. In the new manual, mania/hypomania or mixed features occurring after the administration of a substance and persisting for one week or beyond five half-lives of the substance after its discontinuation is now considered sufficient evidence for a diagnosis of bipolar disorder.

Finally, Fawcett emphasized the crucial inclusion of an "anxious distress specifier" for all of the mood disorders in Section 2 and the inclusion in Section 3 of severity ratings for anxiety.

"This is a very important change that I hope doesn't get ignored," he said. "There is a lot of evidence that comorbid anxiety predicts treatment outcome, and severe anxiety predicts suicide risk. It's so important for clinicians to pay attention to this, and I am hoping that it will stimulate development of new and better treatments for individuals with substantial anxiety levels and either bipolar or major depressive disorder." PN

Additional information, including video interviews with William Carpenter, M.D., on schizophrenia, and Ellen Frank, Ph.D., on mania, hypomania, and mixed episodes, can be accessed at http://www.psychiatry.org/dsm5.

PROFESSIONAL NEWS

Global Initiative Improves Community-Based Care

The Global Initiative on Psychiatry is taking a local approach to helping mentally ill individuals in low- and middle-income countries around the world.

BY AARON LEVIN

Last century's Cold War between East and West consisted of more than saber-rattling and nuclear stockpiles. The Soviet Union often silenced political dissidents by giving them phony psychiatric diagnoses and locking them up in mental hospitals for years on end (*Psychiatric News,* December 10, 2010).

In response to this political abuse of psychiatry, a number of professional groups in the West came together to form the International Association on Political Use of Psychiatry to pressure the Soviet Union on its treatment of such "patients."

"As psychiatrists, we wanted to protect psychiatry, so under the leadership of Mel Sabshin and others, we persuaded the World Psychiatric Association to establish it first ethics committee," recalled Lawrence Hartmann, M.D, of Cambridge, Mass., who was active in the movement. The Soviet psychiatric society resigned from the WPA before it could be expelled.

When the Soviet empire fell, the organization did not, but instead evolved from aiding political prisoners to improving mental health care in the same regions.

"We looked for ways to strengthen the WPA by supporting those in the organization who want strong ethics standards," said Hartmann.

Now, after several decades and a couple of name changes, the organization is called the Global Initiative on Psychiatry (GIP) and is dedicated to "the development of mental health care services in low- and middle-income countries" around the world.

The GIP works to improve community-based care for individuals with mental illness or developmental disabilities, as well as those with mental health problems deriving from war, disasters, or HIV/AIDS.

Initially, some historical momentum led the group to a focus on the former Soviet Union and its satellite countries. GIP established offices in Lithuania, Bulgaria, and Georgia, but also works in several other former Eastern Bloc countries, from Poland to Tajikistan. Beginning in 2005, the organization expanded its operations to parts of Africa and Asia.

Decentralized Approach Preferred

The GIP works through its local offices rather than parachuting in experts from other countries.

The approach is deliberately decentralized, said Robert van Voren, Ph.D., the GIP's executive director, who is based in Hilversum, the Netherlands, and is the author of *Cold War in Psychiatry* (Rodopi, 2010). "Our approach may take longer, but in the long run is more sustainable."

"We work within the existing culture and resource structure and, if necessary, within the existing prison systems," said Thomas Barrett, Ph.D., president of GIP-USA, the organization's affiliate in the United States. "There's no point in imposing a solution if it collapses when you leave."

Global Initiative on Psychiatry

GIP Executive Director Robert van Voren, Ph.D. (center) in 2010 with two activists who battled Soviet psychiatric abuses: the late Melvin Sabshin, M.D., former APA medical director (right), and German psychiatrist Jochen Neuman, M.D.

In fact, the GIP is actually not so much an organization as an idea, van Voren told *Psychiatric News*.

"Of course to further an idea you need some structure, and that is what we established, although it is a very small, horizontal, and democratic one," he said. "Our idea is that mental health services should be locally empowered, locally adapted, community based, user oriented, and focused on keeping people with mental illness in society, instead of taking them out."

U.S. Chapter Focuses on Prison Population

GIP-USA is working to revive the organization in this country, and van Voren hopes the newly reinvigorated U.S. chapter will play three roles: supplying expertise, raising funds, and addressing the problems of mentally ill offenders in the U.S. prison system.

Already, it has set as its first task the problem of prisoners who have a serious mental illness. They make up 17 percent of the population in prisons and jails, compared with just 5 percent of the general population, said Barrett.

"The system basically creates criminals—people who are 'mad and bad'—and that is something that needs to be addressed," said van Voren. "We work in underdeveloped countries, trying to set up services, applying for U.S. funds, and in the U.S. the situation is sometimes even worse than in the [other] countries where we operate. I think that is unacceptable."

GIP-USA, in collaboration with the National Association of State Mental Health Program Directors and the National Criminal Justice Association, has submitted a grant proposal to the Open Society Foundation to fund an 18-month study of best practices for working with adult mentally ill offenders in the U.S. criminal justice system.

"Many could be better served in their communities," said Barrett.

Finally, the GIP remains in touch with its roots in human rights, especially as they apply to psychiatric patients and systems. Fighting stigma and pushing for changes in national health policy are not the only goals. Even small advances, like obtaining the right for forensic patients in Sri Lanka to walk through a hospital garden, are counted as victories. PN

Information about the Global Initiative on Psychiatry is posted at http://www.gip-global.org/. More about the campaign against Soviet abuse of psychiatry can be accessed in *Psychiatric News* at http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=113889 and at http://psychnews.psychiatryonline.org/newsArticle.aspx?articleid=113863.

Rule on Dispensing Buprenorphine Eased

Addiction-treatment programs now have more flexibility in dispensing buprenorphine to individuals addicted to opioids.

BY JOAN AREHART-TREICHEL

A new federal rule has been issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) concerning the dispensing of buprenorphine in opioid-abuse treatment programs.

The rule, which took effect January 7, allows these addiction-treatment programs more flexibility in dispensing take-home supplies of buprenorphine, removing restrictions on the length of time a patient needs to be in treatment to receive take-home supplies of the medication.

"This is a very positive development and should lead to increased access to treatment," John Renner, M.D., associate chief of psychiatry at the VA Boston Healthcare System and chair of the APA Council on Addiction Psychiatry, said in an interview with *Psychiatric News*. "It gives opioid treatment program clinicians the full range of treatment options now available to physicians in office-based practice. Treatment decisions will now be more flexible and patient-centered rather than constrained by programmatic regulations. It should also make it easier to shift patients between methadone and buprenorphine, depending on their treatment needs. I think most clinicians and patients will see this as a very welcome change," Renner stated.

The change in the federal buprenorphine rule will not affect requirements for dispensing methadone—the other opioid-agonist treatment medication used by programs that treat opioid addiction.

SAMHSA officials based the change in the restrictions for dispensing buprenorphine on several factors. These include differences in the abuse potential between methadone and buprenorphine, as well as actual abuse and death rates in treated opioid addicts. Buprenorphine is lower in both of these categories than is methadone. PN

More information about the federal rule on buprenorphine is posted at http://www.ofr.gov/OFRUpload/OFRData/2012-29417_PI.pdf.

FROM THE EXPERTS

Response, Remission, and Recovery in Schizophrenia

BY JOHN LAURIELLO, M.D.

"So what is Greg's prognosis?" asked his parents. It had not been the first or even second question they had asked. In fact, it took several weeks for them to begin to accept the possibility that their son had schizophrenia. It seems like a straightforward question to ask, but the answer is rather complicated. My usual answer is that schizophrenia is a treatable illness, and recovery is possible. Having treated patients for over 20 years, I know that Greg could respond well enough to be a working member of society, even have a family of his own. However, I also know that there is a chance he could be plagued by overwhelmingly disabling, and possibly lifelong, symptoms.

Response

When patients with cancer show improvement, they are said to have had a response to treatment, but only when they have no more detectable cancer cells in their body have they achieved remission. This does not mean that patients are "cured" or without relapse risk. In fact, patients may be asked to continue some form of chemotherapy to maintain their remitted state. A full recovery usually requires a specified time free of cancer (for example, five years) and return to previous functioning.

In contrast, in pharmaceutical industry-sponsored clinical trials for schizophrenia, response is often defined as a 20 percent reduction in positive and negative symptoms. These scores, though useful for approval of new medications by government regulatory agencies, inadequately capture all symptom domains, especially cognitive and social functioning.

For the last 50 years, most clinicians would say that response is a meaningful reduction in psychosis, a compliant patient, and few, if any, rehospitalizations. Getting to remission was deemed a luxury that a few lucky patients might achieve. Cynically, some would even say that getting to remission is rare, and those who recover did not have schizophrenia in the first place.

Remission in Three Steps

Believing a patient can achieve remission is step 1. Defining what we mean by remission is step 2, and getting the patient to remission is step 3. Many of us clinicians believe the bar has been raised to expect and strive for remission, so let's assume we have made the first step. Defining remission is then necessary.

There have been several attempts over the last 15 years to define remission in schizophrenia, using sets of criteria that quantify clinically meaningful improvement and a time criterion to demonstrate sustained improvement. A recent example of usable remission criteria was proposed by the Remission in Schizophrenia Working Group, a group assembled to create a consensus operational definition that could be used both retrospectively, when evaluating older studies, and prospectively for future studies. It requires that patients maintain scores of mild or less in three dimensions (psychoticism, disorganization, and negative symptoms) for at least six months.

Getting to remission is challenging and merits a few "warnings" along the way. First, do not let the pursuit of symptom control be your "Moby Dick." Just as Captain Ahab was obsessed to the ruin of his ship, eradicating psychosis at all costs can be to the detriment of the patient. If the cost includes unbearable side effects (extrapyramidal side effects, sialorrhea, sexual dysfunction) or long-term morbidity (tardive dyskinesia or obesity), it may not be worth eliminating every hallucination. Instead, alleviating symptoms to a mild level may adequately allow the patient to better tolerate the medication. Second, don't expect medication alone to get patients to remission. This often requires adjunctive case management and family, social, and vocational therapies.

Finally, don't expect things to stay the same once remission is achieved. There are multiple reasons why a patient may become symptomatic again. These include, but are not limited to, noncompliance or partial compliance with medications or other treatment modalities, substance use, and worsening of underlying psychopathology. An analogy I often use for the last is the following: You have a very nice beach house, and in front of your home you have a four-foot wall. For many years, the wall provides protection against rain and high tides. But one year, a hurricane hits and the four-foot wall is inadequate to hold the water from rushing into your home.

So, too, we often prescribe patients doses of medication that appear to keep them relatively stable, and to our surprise, despite being treatment adherent, the patient worsens. Symptoms can be like storms, unpredictable and severe. At that time, the medication regimen may need to be adjusted but can eventually return to the lower, more tolerable maintenance dose.

Recovery

It is useful to think of recovery as the next level after remission. Not only are symptoms controlled, there are sustained gains/or maintenance in cognitive, social, and vocational functioning over a longer period. With this considered, we include the UCLA criteria developed by Lieberman and colleagues as a recovery measurement. The UCLA criteria seek to provide a "multimodal normative inventory of personal assets and freedom from psychotic symptoms." The UCLA criteria include sustained improvement for at least two years in four domains: symptom remission, appropriate role function, ability to perform day-to-day living tasks without supervision, and social interactions. The developers also delineated several factors predicting recovery: good premorbid functioning, intact cognitive performance, a short duration of untreated psychosis, robust response to antipsychotic medications, a supportive social network, and access to psychiatric care.

A common question is, "How many patients with schizophrenia can recover (remember Greg's parents' question)?" It has long been believed that early diagnosis and treatment of schizophrenia should provide the best outcome and greatest chance for recovery. In a group of patients with a first episode of schizophrenia studied by Robinson and colleagues, full recovery rates were found to be low, with only one-eighth of those in the study meeting criteria for two or more years.

Although recovery was rare, several predictors of recovery were identified, including better cognitive performance, shorter period of psychotic symptoms prior to enrollment in the study, and more normal cerebral asymmetry. The finding of length of history of psychosis as a predictor suggests that the longer patients are psychotic and untreated, the lower the chance for recovery. This finding underscores how vital it is that patients with their first break of psychosis be brought for evaluation and treatment as soon as possible.

So we can amend our answer to Greg's parents' question: "What is his prognosis?" It depends partly on how quickly we have identified the illness and whether we can get him to remission. Remission is possible. It requires reasonable control of psychotic symptoms, and a new focus on cognitive and negative symptoms leading to better functional outcomes. While challenging, sustained remission is the only way functional recovery can be attained. PN

References for this article are posted at http://www.psychnews.org/update/experts_2_36.html.

John Lauriello, M.D., is a professor and Chancellor's Chair of Excellence in Psychiatry in the Department of Psychiatry at the University of Missouri School of Medicine and medical director of the University of Missouri Psychiatric Center. He is a co-editor of *Clinical Manual for Treatment of Schizophrenia* from American Psychiatric Publishing. APA members may purchase the book at a discount at http://www.appi.org/SearchCenter/Pages/SearchDetail.aspx?ItemId=62394#.

Newtown

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of the Yale Child Study Center, and Steven Southwick, M.D., a posttraumatic stress disorder specialist at the West Haven Veterans Affairs Medical Center, will lead the training.

Danbury Hospital has only a small child and adolescent psychiatry department, so it will concentrate on adult services while linking younger people to primary care physicians, he said. The hospital will train the latter to use screening tools and look for somatic complaints in children that may have been triggered by the event.

In the longer term, coordination for local resources will be managed by Newtown Youth and Family Services, said Jennings. Local resources should be adequate to serve those who need services.

"This is a pretty therapy-rich area, between private practices and nonprofit agencies," he said. "People in Newtown want to stay in Newtown, so we're trying to be sensitive to that view."

The coordinating council must build for the long term, said Herrick. At one early meeting, a state official reported that health officials from Colorado's Columbine High School and Aurora, Colo., scenes of previous mass shootings, had called to offer support. They also noted that people in those towns reexperienced their own tragedies when they heard about Newtown.

"So we have to make a longstanding commitment in our community to have services available," said Herrick.

Perhaps that will also mean having that St. Bernard on call. PN

The Newtown Youth and Family Services' Web site is http://www.newtownyouthandfamilyservices.org.

MEMBERS IN THE NEWS

Aaron Levin

Employees of Stones on 5th construct vignettes like this village scene (left) out of broken or cast-off pieces of marble and granite. They also produce jewelry (right) from recycled marble.

Old Stones Build New Foundations

At one New York company, psychiatric patients and others recycle building materials and rehabilitate themselves.

BY AARON LEVIN

No, "Stones on 5th" is not the World's Greatest Rock 'n' Roll Band strolling down New York's famed avenue.

The name belongs to a small company that takes fragments of leftover or broken stone used for countertops or shower stalls and turns them into salable works of art. But this marble and granite fabrication business recycles not just stone but lives as well.

Psychiatrist Martin Korn, M.D., runs Stones on 5th in New Rochelle, N.Y. His employees are people who may have psychiatric disorders or members of their families or who are just underemployed.

"They can come in and learn a skill," said Korn in an interview. "I wrap the job around the individual."

Korn started Stones on 5th in 2007, inspired by the chunks of leftover material after the kitchen and bathroom in his house were remodeled.

"We use everything," he said. "Our motto is 'No stone left behind.' "

The workers create a variety of products from the stone: plaques, jewelry, religious objects, or small tableaux of weddings or village scenes.

Korn is hardly bothered by the fact that others consider the raw material scrap. "The beauty is in the break," he said. And the random way that each chunk of stone fractures means that many pieces are truly one of a kind.

Aaron Levin

Psychiatrist Martin Korn, M.D., helps patients and others return to productive lives by working at the stone recycling company he founded in New Rochelle, N.Y.

The employees can set their own time and work when they feel most efficient. But once they get familiar with the operation, Korn nudges them toward regular business hours as a way to prepare them for the less-accommodating general workforce.

"This is a true wellness system," he continued. "We psychiatrists work with medications and therapy, but the ability of our patients to get and keep work is essential."

Stones on 5th differs from other supported-employment programs in that the company accepts no grants. Korn still subsidizes it out of his own private practice, but he hopes the company will soon produce enough revenue so that it won't require this continued input.

After Korn completed his undergraduate, medical school, and psychiatric training at the University of Pennsylvania, he conducted research on the neurobiology of suicide and violence. He also held a number of clinical positions at Mount Vernon Hospital in Mount Vernon, N.Y., over the years.

However, he has also had an interest in social enterprises. In the early 1990s, he developed Econet, a "socially dedicated" corporation intended to serve the homeless and other severely socially disadvantaged people.

With more marketing support, the investment in equipment and people could pay off, he said. So far, any profits have been plowed back into training the workers. Because some of them are his patients, for ethical reasons he does not accept any of the proceeds from the company.

"The next stage is getting it to work by itself," he said. "It's not just a business; we want to develop a model for others."

And perhaps his idea has a longer history, one with a similar moral. After all, as Psalm 118 says: "The stone that the builders rejected has become the chief cornerstone."

Korn may not have had exactly that in mind, but he has found a way to recycle rejected stone and build a new foundation for his patients and other workers. PN

The Web site for Stones on 5th is http://www.stoneson5th.com/.

PSYCH_IT

Implementing an EHR: A Firsthand Account

BY LORI SIMON, M.D.

As a psychiatrist in a solo private practice, I was probably typical of many of my colleagues by having an assortment of places in which I kept information about my patients. I used Microsoft Outlook for appointments; Word for patient information, progress notes, and prescription tracking; and Excel for patient accounts. My system was certainly not an integrated, fully functional electronic health record (EHR), but it worked for me.

At the end of 2010, I became a participating Medicare provider and began investigating the government's Meaningful Use program, which provides $44,000 over five years to clinicians who use an EHR in a prescribed manner. In the Exhibit Hall at APA's 2011 annual meeting, I came across one particular EHR system developed by a company that specializes in software for the mental health field. I liked what I saw and decided to take the plunge. During the next two months, I began setting up my patient records in the EHR. I continued using Outlook for my appointments and decided not to migrate my old progress notes into the EHR. The information I did enter included demographics, insurance, all current and previous medications, diagnoses, and allergies.

As for billing, I started using the system for billing each subsequent session after June 1. In December 2011, I was able to satisfy the Meaningful Use criteria, and I received my first installment incentive payment of $18,000.

Lori Simon, M.D., serves on APA's Committee on Electronic Health Records. She became a psychiatrist after spending 18 years in the computer field developing and implementing software applications, as well as working as a systems engineer/health industry specialist for IBM. She has a solo private practice and is on the voluntary faculty of New York Presbyterian Weill Cornell Medical Center.

LEGAL NEWS

Judges Get Help Handling Mentally Ill Defendants

A Florida judge heads a program to educate U.S. judges on managing criminal cases involving defendants with mental illness.

BY AARON LEVIN

The Judges Leadership Initiative has begun educating judges and psychiatrists about the interface between the criminal justice system and the psychiatric community, said Judge Steven Leifman, J.D., of Florida's 11th Judicial Circuit.

Leifman is spearheading the initiative with the help of a grant from Janssen Pharmaceutical Companies through the American Psychiatric Foundation (APF), in cooperation with the Council of State Governments' Justice Center.

"We're developing a curriculum for judges and psychiatrists to work collaboratively on ways to handle cases in court," said Leifman in a recent interview at APA headquarters.

The initiative sponsored a session at the APA Institute on Psychiatric Services in New York in October 2012, in which a group of judges and psychiatrists were trained to train other judges to better deal with defendants who have a mental illness.

As a next step, the Judges Leadership Initiative is developing a series of videos showing judges just how to manage a case in court when it involves an individual with mental illness. The videos will present vignettes or case studies demonstrating common behaviors of people who have a mental illness.

"We welcome participation by psychiatrists," he said. "We're judges, not doctors, and we don't want to pretend to be, and we really need the help from the psychiatric community on how we should be handling these individuals."

Leifman also wants to encourage judges to collaborate with others to make significant changes in the judicial system and in their communities.

"One way to do this is to work with all the stakeholders in the community," he said. "So we're teaching judges how to bring all those groups together and educate law-enforcement personnel about how to recognize someone in a crisis, how to deescalate situations, and where to take [mentally ill individuals] as opposed to arresting them."

Aaron Levin

Miami Judge Steven Leifman, J.D., is working with the American Psychiatric Foundation and others to educate judges about the best ways to manage criminal cases with defendants who have mental illness.

In Miami-Dade County, where Leifman presides, more than 3,600 officers have been trained in crisis-intervention policing, he said. Last year, two agencies in the county handled more than 10,000 mental health calls and, remarkably, made only 45 arrests.

"It shows that if you educate people and teach them about mental illnesses, you can make a significant improvement," he said.

Leifman also works to teach judges about diversion programs so that when people with serious mental illnesses are arrested (and the crime is not too serious) alternatives can divert defendants from the criminal justice system and keep them in the community and in the mental health system. The goal is to avoid rearrest and unnecessary hospitalization or incarceration of these defendants.

Some people with mental illness also face criminogenic risk factors that increase their chances of getting arrested, such as co-occurring substance use disorders, illiteracy, living in areas with high crime rates, or hanging around with people who commit crimes.

A demonstration study supported by a grant from the Bristol Myers Squibb Foundation through the APF will assess the effects of an intervention on such individuals.

The program is now under way in Miami-Dade County. Two groups of 50 individuals with criminal records will be compared. One group will receive mental health treatment as usual, while the other will get the same plus a cognitive-behavioral therapy program designed to address their criminogenic issues, said Leifman.

Leifman wants to address another longer-term concern—the fact that many laws pertaining to involuntary hospitalization are at least 40 years old.

"All are based on old neurological science, old ideas, and old stereotypes, and none of it really applies today," he emphasized. "If we would start thinking about this as a medical issue rather than as a justice issue we could keep a lot more people out of jail."

He wants to get both the legal and forensic psychiatry communities talking about this issue, with the goal of ultimately producing a new model law.

"Maybe we can do a joint article for a major law review and a medical journal on why new laws are needed," he said. "The laws now based on dangerousness, but they should be based on treatment."

Leifman recently received the Productive Life Award from the Brain and Behavior Research Foundation for his contributions to helping people recover from mental illness. PN

More about the Judges Leadership Initiative is posted at http://consensusproject.org/JLI/. To access an audio interview with Leifman, scan the QR code with your smartphone code reader or go to http://www.psychnews.org/update/audio/Leifman.mp3

The effort to install the EHR was substantial. During May and June, I had to enter all of the above information. On two occasions, I realized that I had set up the medication and billing data incorrectly, primarily because I had not yet developed an in-depth understanding of how the software operated; I had received training on the basics, but as with anything new, it takes time to recognize nuances. As a result, I had to reenter a good deal of this information. As I had continued to use another software program to send the Medicare claims electronically, entering the same information into each system was duplicative.

However, I also began to see the benefits of using the EHR system. It has been great to be able to send prescriptions electronically, and some pharmacies send renewal requests directly to the EHR system. Writing progress notes has always been a real chore for me, but some of the features of the EHR system have made it much easier to do so, and I was able to customize the format of my notes. I used to carry around hard copies of my patient demographic and medication files in case a patient called when I didn't have my laptop with me. I can now access the same information on my smartphone using a function of the EHR. Last March, I began using the EHR system to submit both Medicare and some commercial insurance claims electronically, which has greatly simplified that process. I have been amazed at how much faster the commercial insurance companies process the claims filed electronically compared with those submitted on paper. Although I am not in-network with any commercial insurers, the faster processing has enabled patients to pay me more quickly.

I have continued to use Outlook for my appointment scheduling, primarily because I am waiting for the EHR vendor to improve that function. At times, I also still use an external drug information/interaction software product, because I like it better than the one utilized by the EHR. Other than that, I am now using the EHR for all of my patient-related tasks.

Although my primary reason for getting an EHR was to take advantage of the government incentive program, I can honestly say that I have benefitted in many more ways. It has greatly simplified my record keeping, prescription management, and billing. Because everything I need is now in one place, it is a lot easier to find patient information, get the phone number of a colleague, or talk to an insurance company, for example. I'm not sure that using an EHR has made me a better psychiatrist, but it has definitely made it easier for me to be the kind of psychiatrist I want to be. PN

Do you have an EHR adoption story to share? Contact me—Steven R. Daviss, M.D.—at drdaviss@gmail.com. In addition to coordinating this column, I am chair of the APA Committee on Electronic Health Records, an Assembly Representative, Health Standards Committee member at URAC, HIE Policy Board member at the Maryland Health Care Commission, a clinical assistant professor at the University of Maryland, chair of the Department of Psychiatry at Baltimore Washington Medical Center, and coauthor of the book *Shrink Rap: Three Psychiatrists Explain Their Work*. I tweet at @hitshrink and blog at HIT Shrink.

CLINICAL & RESEARCH NEWS

SSRIs Don't Show Link to Stillbirths, Neonatal Deaths

Adverse events were explained by such factors as the mother's psychiatric illness, older age, and harmful behaviors.

BY JOAN AREHART-TREICHEL

In a major new study, researchers found that use of SSRI antidepressants during pregnancy was not associated with stillbirths, neonatal deaths, or postneonatal deaths.

This finding on a topic that has generated considerable controversy in recent years comes from a large Scandinavian study published in the January 2 *Journal of the American Medical Association (JAMA).* The lead researcher was Olof Stephansson, M.D., Ph.D., an associate professor and senior consultant in obstetrics and gynecology at the Karolinska Institute in Stockholm, Sweden.

The study included more than 1.6 million women and the births of their single children in Denmark, Finland, Iceland, Norway, or Sweden from 1996 to 2007. Such a large-scale study was feasible because of the national registry systems in those countries, where residents are assigned a unique identification number.

The researchers used patient, birth, and prescription registries to obtain information about the women, their health, and their health behaviors—for example, whether they had high blood pressure or diabetes, smoked, or had been hospitalized for a psychiatric illness.

The researchers used prescription registries to determine whether any of the women had filled prescriptions for an SSRI antidepressant from three months before the start of a pregnancy until giving birth. They found that some 29,000 (2 percent) had. Compared with the rest of the study population, those women were more likely to be older and smokers and have high blood pressure and/or diabetes and a history of psychiatric hospitalization.

This finding didn't surprise him, Stephansson told *Psychiatric News.* "It is known that women with depression tend to use alcohol and smoke more during pregnancy, and the likelihood of getting depression and medication for depression increases with age. However, the association with hypertensive disease and diabetes was less known to me."

The researchers then evaluated three outcomes: stillbirth (intrauterine death after 22 or more weeks of gestation), neonatal death (death within 0 to 27 days following birth), and postneonatal death (death from 28 to 364 days after birth). Information on stillbirths was obtained from the medical birth registries in each country and on neonatal and postneonatal deaths from the causes-of-death registries, which contain information on the date and causes of death for all individuals who resided in those countries at the time of their death. There were 6,054 stillbirths, 3,609 neonatal deaths, and 1,578 postneonatal deaths.

Finally the researchers assessed whether children of women who had used an SSRI antidepressant during pregnancy had more stillbirths, neonatal deaths, or postneonatal deaths than children of women who had not used one of these drugs during pregnancy.

Confounds Change the Outcome

Compared with women who had been unexposed to SSRIs during pregnancy, those who had taken these medications experienced significantly more stillbirths and postneonatal deaths, but not neonatal deaths, the researchers found. However, when possibly confounding factors such as maternal psychiatric illness, maternal cigarette smoking, and advanced maternal age were considered, there were no longer any significant differences between the exposed and unexposed women for stillbirths, neonatal deaths, or postneonatal deaths.

Thus "the present study of more than 1.6 million births suggests that SSRI use during pregnancy was not associated with increased risks of stillbirth, neonatal death, or postneonatal death," the researchers concluded. "The increased rates of stillbirth and postneonatal mortality among infants exposed to an SSRI during pregnancy were explained by the severity of the underlying maternal psychiatric disease and unfavorable distribution of maternal characteristics such as cigarette smoking and advanced maternal age."

"I am glad that these researchers have been able to do what no one has yet done, and the study is a needed addition to the literature," psychiatrist Harold Koplewicz, M.D., president of the Child Mind Institute in New York City, told *Psychiatric News.* "Though there are a few criticisms one could make of the design, I believe that the authors convincingly demonstrate through the multivariate analysis that their observations are valid. . . . I would never urge anything less than caution when treating a pregnant woman with any medication. But this study is helpful in reminding us to be as concerned with the effects of the disease as we are about the treatment. Unfortunately, the idea is still radical to many people."

The study was funded by the Swedish Society of Medicine and the Swedish Pharmacy Company. The researchers reported that the latter was not involved in the study's design, implementation, or data interpretation.

Other Studies Address Related Issues

This study is one of the latest to explore the impact of SSRI use during pregnancy on fetal outcome. Two studies that appeared in the June 28, 2007, *New England Journal of Medicine* suggested that if a woman takes SSRIs during the first trimester of pregnancy, it may raise the risk of certain birth defects in her offspring. The researchers in that study emphasized, however, that the overall risk is small and that untreated depression can also be deleterious to the fetus (*Psychiatric News,* July 20, 2007).

In a study published March 16, 2009, in *AJP in Advance*, researchers found that pregnant women with continuous untreated depression and those with continuous exposure to SSRIs had similarly elevated rates of more than 20 percent for preterm delivery (*Psychiatric News*, April 3, 2009). And in a study published January 2, 2009, in *AJP in Advance*, researchers found a link between SSRI exposure in late pregnancy and a significantly higher risk for gestational hypertension and preeclampsia (*Psychiatric News*, April 3, 2009). PN

An abstract of "Selective Serotonin Reuptake Inhibitors During Pregnancy and Risk of Stillbirth and Infant Mortality" is posted at http://jama.jamanetwork.com/article.aspx?articleid=1555130.

Psychotic Symptoms Increase With More Frequent Meth Use

There is a fivefold increase in psychotic symptoms during periods of methamphetamine use compared with periods of abstinence, with the relationship being dose-dependent.

BY MARK MORAN

There appears to be a large dose-dependent increase in the occurrence of psychotic symptoms during periods of methamphetamine use, according to a study in published online January 9 in *JAMA Psychiatry.*

Australian researchers found a fivefold increase in the likelihood of psychotic symptoms during periods of methamphetamine use relative to periods of no use. The increase was strongly dose-dependent: individuals who had used methamphetamine 16 or more days in the prior month were significantly more likely to experience psychotic symptoms than those who had used the drug 15 or fewer days.

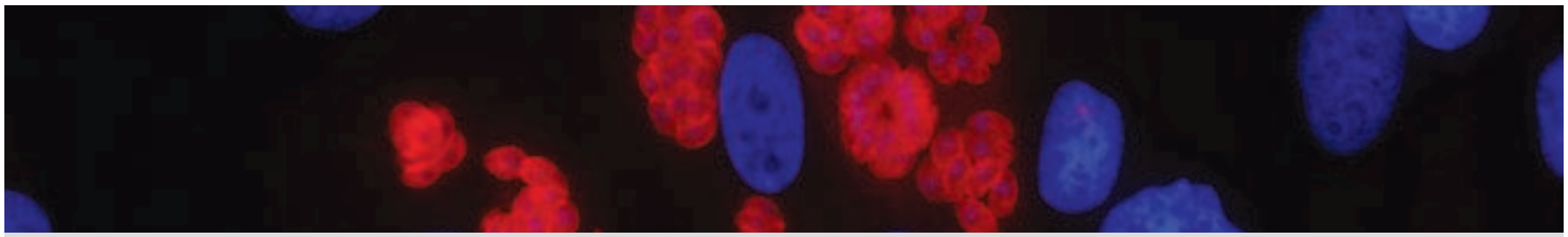
A total of 278 participants aged 16 or older in Brisbane and Sydney, Australia, who met *DSM-IV* criteria for methamphetamine dependence but who did not meet *DSM-IV* criteria for lifetime schizophrenia or mania took part in a longitudinal prospective cohort study consisting of four noncontiguous one-month observation periods. The purpose was to examine the relationship between changes in methamphetamine use and the risk of experiencing psychotic symptoms within individuals over time.

The main outcome measures were clinically significant psychotic symptoms in the past month, defined as a score of 4 or more on any of the Brief Psychiatric Rating Scale items of suspiciousness, hallucinations, or unusual thought content. The number of days of methamphetamine use in the past month was assessed using the Opiate Treatment Index.

Sixty percent of the sample reported psychotic symptoms during at least one of the observed months in the study period. Of those months during which psychotic symptoms were present, 71 percent involved suspiciousness, 35 percent involved unusual thought content (that is, delusions), and 51 percent involved hallucinations.

Psychotic symptoms were more common during periods of methamphetamine use, with a strong dose-response effect between number of days of methamphetamine use and psychotic symptoms. After adjusting for effects of other drug use, the researchers found that methamphetamine use was associated with a fivefold increase in the odds of experiencing psychotic

see ***Meth Use*** *on page 23*



Claudia Bordón, Johns Hopkins University School of Medicine.

This photo shows *Toxoplasma gondii* tachyzoites replicating within human foreskin fibroblasts.

Psychiatrist Hunts for Evidence Of Infection Theory of Schizophrenia

After decades of searching with limited success for the cause, or causes, of schizophrenia, an old, little known theory is attracting renewed attention.

BY JUN YAN

The theory that psychotic disorders are caused by infection went for decades without receiving more than an occasional raised eyebrow from researchers, but new studies have revived interest in its validity. If the theory turns out to be correct, psychiatry could begin to find cures in antimicrobials.

The prime suspect is *Toxoplasma gondii*, a protozoan parasite carried primarily by cats.

"When we started, it was considered a crazy idea," psychiatrist E. Fuller Torrey, M.D., executive director of the Stanley Medical Research Institute (SMRI), told *Psychiatric News*. In the early 1970s, Torrey began to suspect an infectious origin of schizophrenia. He has been on this trail for decades.

Torrey does not have direct evidence to convict *T. gondii* as the culprit, but quite a bit of circumstantial evidence exists. For one, *T. gondii*, in its dormant form as cysts, is known to invade brain tissue in humans and remain there for as long as the person lives.

Second, congenital infection with *T. gondii* is known to cause brain abnormalities, including mental retardation, deafness, and seizures in the fetus. This is why pregnant women are routinely tested for *T. gondii* antibody, a sign of infection or past exposure, and are warned against handling cat litter.

Third, epidemiological data from Eastern Europe and Asia for over a half century have consistently shown that a *T. gondii*-positive test is more common in those with schizophrenia than in the general population.

Another piece of the evidence puzzle is that *T. gondii* can manufacture dopamine. "We know toxoplasma has the genes to produce a precursor of dopamine," said Torrey. Excess dopamine in the brain has long been associated with psychosis. "This idea that excess dopamine [in schizophrenia] may be coming from an outside organism is kind of mind-blowing," he said, marveling at the "smart little organism."

Besides dopamine, *T. gondii* may also cause human nerve cells to secret GABA, another neurotransmitter, according to a study by researchers at the Karolinska Institute in Sweden and published online in *PLoS Pathogens* December 6, 2012.

"[The cysts] are not replicating in the brain, but they do appear to be active in some way," Robert Yolken, M.D., a professor of pediatric infectious disease at Johns Hopkins University (JHU) Medical School, told *Psychiatric News.* An expert in infectious diseases, he has been a long-term research collaborator of Torrey's. Yolken heads the developmental neurovirology lab at JHU. In addition to producing neurotransmitters, the parasite may manipulate brain functions by inducing an autoimmune response, he suspects.

Infection Theory Long Ignored

Despite the slowly accumulating findings supporting the infection theory, it has been unable to penetrate mainstream psychiatric research. Torrey believes that's because the theory does not fit into preexisting paradigms of psychiatric disorders. "There are 'fashions' in scientific research, and the fashion in psychiatric research for many years has been genetics and neurotransmitters," he said. "Things that fall outside the fashions are basically ignored."

Yet genomic studies have failed to identify genes that can explain schizophrenia. Curiously, the chromosome region that has come up repeatedly in association with schizophrenia is the HLA genes involved in immune response, Torrey noted, which again points to a possible infectious element in the pathology.

Perhaps it is not surprising that the infection theory has gotten little notice. After all, it is difficult for humans to imagine that their brain, self-regarded as the most complex organ in the natural world, can be so easily hijacked by a primitive single-cell organism. Also, noncongenital T. gondii infection causes no overt psychiatric symptoms in humans

However, scientists know that the parasite alters mouse behaviors in subtle and strange ways. For example, mice infected with *T. gondii*, which is shed in cats' feces, become bolder and lose their natural fear of the smell of cat urine. This phenomenon makes sense, as a mouse not afraid of cats is more likely to be eaten by cats, thus allowing the *T. gondii* cysts to reinfect the primary host, cats, and completing its lifecycle.

Like mice, humans can become a secondary host, usually through ingesting undercooked meat or contaminated water. Research on what *T. gondii* does to humans has been mostly done by biologist Jaroslav Flegr at Charles University in Prague. He has shown that men who have been infected by toxoplasma are more suspicious, jealous, and impulsive than men who have not been infected, but women with the infection tend to show more warmth and sociability. He also found that toxoplasma-positive individuals have a higher risk of causing motor-vehicle accidents. Torrey thinks Flegr's research is intriguing and credible but "needs replication."

Probably a Predisposing Factor

The prevalence of *T. gondii* has been estimated at 20 percent to 30 percent in the U.S. population. Therefore, it cannot be a sufficient cause for schizophrenia. "Genetic predisposition is a possible factor," Torrey suggested, citing the link between HLA genes and schizophrenia. Different strains may have different effects on the infected individual. "We know some strains are more lethal than others," he noted. In addition, Yolken proposed that the timing of toxoplasmosis may be important. Perhaps schizophrenia would occur only in those with early-in-life infection by certain virulent strains.

When pressed for his own beliefs, Torrey said he is convinced *T. gondii* is "one etiological factor in a majority of cases of schizophrenia."

T. gondii has been suspected of increasing the risk of bipolar disorder with psychotic features and suicide (*Psychiatric News*, January 4).

For decades, SMRI has been the major funding source for research on infection as a cause for psychotic disorders. Recently, however, more researchers have joined the quest. In addition to the Swedish researchers, a group of French researchers published a study on human endogenous retrovirus type-W and schizophrenia in the December 4, 2012, *Translational Psychiatry.* The retrovirus is incorporated into the human genome and can be passed to offspring. The authors found greater transcription of the viral envelope protein in schizophrenia and bipolar patients than in healthy controls, as well as an association between the viral transcription and *T. gondii* exposure.

"Now we're almost respectable," Torrey said with a chuckle.

Experimental Treatment May Prove Case

"Ultimately no one is going to believe our theory until you can show that, if you treat a [schizophrenia] patient with antitoxoplasma treatment, the person improves," said Torrey. The hurdle is that antitoxoplasma drugs were discovered to treat malaria and are barely effective against *T. gondii*, especially in the dormant stage. Crossing the blood-brain barrier to reach cysts in the brain poses additional difficulty.

Torrey and Yolken have identified a candidate drug originally developed for malaria and have high hopes for its viability. The yet-unnamed drug is effective in killing *T. gondii* cysts in mice and is in preclinical development in preparation for human testing.

Meanwhile, Yolken, who owns two cats, recommends people handle cat litter with care and keep cats indoors as much as possible. PN

A review of research literature on toxoplasmosis and schizophrenia is posted at http://www.stanleyresearch.org/dnn/LaboratoryofDevelopmentalNeurovirology/ToxoplasmosisSchizophreniaResearch/tabid/172/Default.aspx.

CLINICAL & RESEARCH NEWS

Age of Child at Death Can Affect Parents' Mortality

Losing a child to sudden, unexpected death may seriously affect the health and other key aspects of life of the parents.

BY AARON LEVIN

The tragic deaths of 20 children in Newtown, Conn., in December brought to the forefront recent research on the health outcomes of bereavement by parents who have lost their children.

Parents in Newtown will be at risk for at least several years and should be followed to see that they have access to care, said James Bolton, M.D., an assistant professor of psychiatry at the University of Manitoba, in an interview with *Psychiatric News*.

"We have to recognize that they are vulnerable and that treatment needs to be readily available."

Bereavement responses vary widely, of course. Some people are more resilient than others. However, the death of a child—regardless of age—can have harmful physical effects on surviving parents, wrote Mikael Rostila, Ph.D., and colleagues in the October 2012 *Journal of Epidemiology and Community Health*. Rostila is an associate professor of sociology at the Centre for Health Equity Studies (CHESS) at Sweden's Stockholm University and the Karolinska Institute.

The researchers distinguished between death by "natural" causes, such as disease, and "unnatural" ones, such as by suicide, homicide, or accident.

"Our data . . . indicate that unnatural causes of child death have a stronger impact than natural deaths on parental mortality, but mainly among mothers who lost young children (aged 10-17 years)," said the researchers. The mortality effect on fathers in the Swedish study was not significant.

"In other age groups we found no difference in the effect of natural versus unnatural child deaths on the mortality of parents," said Rostila in an interview. "In other words, unnatural child deaths are particularly detrimental for mothers when the child is young at the time of death."

Mothers of children aged 10-17, the youngest age group in this study, faced an increased risk of 31 percent in all-cause mortality, but that increase was driven largely by an increased risk of 48 percent among mothers whose children died unnatural deaths.

Although his study did not cover younger children, Rostila speculated that the death of a child under age 10 might be at least as detrimental given the strong emotional bond and attachment between the child and the parent.

"The death of a young child is also extremely unexpected, which could lead to strong feelings of grief and difficulty in coping with the death," he said.

Rostila and colleagues also found a 26 percent to 33 percent increased association with mortality among the siblings of the deceased child. But so little research has been done on this group that Rostila called them "the forgotten griever[s]."

The psychological effects on parents can crop up in a relatively short time, Bolton pointed out.

In a study published online December 10, 2012, in *Archives of General Psychiatry*, Bolton and colleagues compared parents bereaved by the death of their children by either suicide or motor-vehicle crash.

He and his colleagues found associations in both groups with increased rates of depression, anxiety, and marital breakup, although not with drug or alcohol use disorders.

"There was quite a dramatic effect on parents, but there wasn't much of a difference in outcomes relating to the specific cause of the child's death," said Bolton. "So the parents of children killed in a mass shooting will be a very vulnerable group, and the increased risk will be visible soon, even with the first two years."

Bolton's two-year study was too short to observe physical effects on bereaved parents of a child's death, but the short-term mental health effects are likely to translate into physical effects eventually, he said.

In one respect, the aftermath was different for parents following a suicide. The stigma faced by the parents of children who died by suicide was often manifested by the surrounding community, which shunned them or at least felt awkward in approaching the family, said Bolton. That should not be the case in Newtown, however, where the community has rallied around the parents of the children who were shooting victims at the elementary school, he said. PN

An abstract of "Mortality in Parents Following the Death of a Child: A Nationwide Follow-up Study From Sweden" is posted at http://jech.bmj.com/content/66/10/927.long. An abstract of "Parents Bereaved by Offspring Suicide" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=1483982.

Job Stress, Lack of MH Treatment Increase Risk of Physician Suicide

Stigma about getting mental health care may prevent physicians from seeking treatment when suicidal ideation develops.

BY LESLIE SINCLAIR

Physicians die by suicide more frequently than nonphysicians, a disturbing phenomenon that's been well documented for several decades in the United States. But researchers say details about factors that may contribute to those suicides are lacking.

Katherine Gold, M.D., M.S.W., an assistant professor of family medicine in the Department of Obstetrics and Gynecology at the University of Michigan, and colleagues identified the National Violent Death Reporting System (NVDRS; see box on page 23) as a tool for analyzing the details of physician suicide.

"The NVDRS offers critical, and heretofore rarely available, data on psychosocial, psychiatric, mental health care, medical comorbidity, and substance abuse variables associated with suicide," they wrote in the November 1, 2012, *General Hospital Psychiatry*. "An analysis of these data could contribute to a significantly better understanding of the magnitude and nature of the problem of physician suicide and could lead to new educational, preventive, and clinical interventions."

Gold and her colleagues set out to do just that. They identified 31,636 suicide victims aged 18 and older in the database, 203 of whom were physicians or residents in any specialty. When they analyzed the details of those cases, their results were perplexing: Mental illness was found to be an important comorbidity for physicians—as it was for nonphysicians—but postmortem toxicology data showed low rates of medication treatment. The physicians had significantly higher rates of antipsychotics, benzodiazepines, and barbiturates in their systems than the other suicide victims, but not antidepressants. Toxicological testing was unable to determine whether the substances that were detected were intended to be therapeutic, recreational, or toxic.

ostill/Shutterstock.com

High rates of physician suicide aren't news, but new information details the how and why of these tragic events.

The finding of barbiturates, said the researchers, is "particularly significant because of... infrequent use for therapeutic purposes and known lethal potential. The equally dramatic increased likelihood of measurable antipsychotics being found is unclear as to its significance...."

Gold told *Psychiatric News* that unpublished data from the study indicated that, of the victims who appeared to have some type of mental health disorder, as determined from police reports or from toxicology testing that indicated the presence of antidepressants or antipsychotics in non-overdose deaths, 81 percent of physicians and 79 percent of nonphysicians had a mood disorder: depression, dysthymia, or bipolar disorder.

But where were the antidepressants that would suggest an attempt to treat depression? "We were surprised to find that physicians are more likely to have an unknown mental illness [diagnosed by postmortem toxicology findings], but less likely to have antidepressants in

see ***Physician Suicide*** *on page 23*

CLINICAL & RESEARCH NEWS

Psychiatric Risk Genes Already Active At Birth, Neuroimaging Suggests

Mental illness risk genes that have been linked with brain abnormalities in adults also appear to be associated with the abnormalities in newborns.

BY JOAN AREHART-TREICHEL

Thanks to the exciting new field of neuroimaging in psychiatric genetics, it may be possible eventually to identify people who are at risk of Alzheimer's disease soon after birth.

Rebecca Knickmeyer, Ph.D., an assistant professor of psychiatry at the University of North Carolina, and her colleagues have not only identified in newborns the Alzheimer risk gene variant APOE-e4, but have linked its presence with reduced temporal cortex volume, which is also known to be present in adults with the APOE-e4 variant.

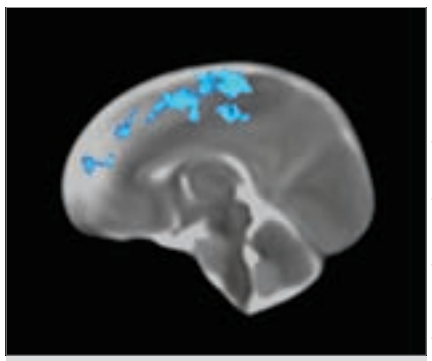
These findings were published January 3 in *Cerebral Cortex*.

But other provocative results emerged from their research as well.

The study included 272 Caucasian infants who received MRI brain scans at University of North Carolina–affiliated hospitals shortly after birth. The DNA of each newborn was tested for common variations in seven genes that have been implicated in various psychiatric illnesses—Alzheimer's, autism, anxiety disorders, bipolar disorder, depression, and schizophrenia—and that have been associated with brain abnormalities in adults. The genes are DISC1, COMT, NRG1, APOE, ESR1, BGNF, and GAD1. The researchers then assessed whether any of these variants could be linked with brain abnormalities in the newborns.

They did in fact find such an association, and not just for the APOE-e4 variant, but for other variants as well.

For example, newborns who had two copies of a particular variant of the DISC1 gene—the rs821616 variant—had reduced gray matter in their frontal lobes, especially in the medial superior frontal gyrus and motor areas as well as in the lateral temporal cortex including the superior and middle temporal gyri. Reduced volumes in the medial superior frontal gyrus have been reported in young adults with two copies of this variant. Also, gray-matter reductions in the superior temporal gyri have been noted in individuals with schizophrenia.



Rebecca Knickmeyer, Ph.D., et al.

This neonate brain image shows gray matter decreases in the brains of neonates with two copies of a variant of the DISC1 gene. The decreases are present in motor areas and have been identified in brains of adolescents with the same variant.

Newborns who had two copies of a variant of the COMT gene—the rs4680 variant—had reduced gray matter in their temporal lobes, especially the hippocampus. Such alterations have also been frequently observed in individuals with schizophrenia.

"Our results suggest that variation in COMT affects neural systems implicated in the pathophysiology of schizophrenia before birth," Knickmeyer and her colleagues said.

Thus "common genetic polymorphisms in putative psychiatric risk genes predict individual differences in brain structure shortly after birth," the researchers concluded. "These variants and the associated neuroimaging phenotypes likely represent stable markers of risk and highlight the critical role of the perinatal period in the etiology of mental illness."

In an accompanying press release, Knickmeyer said that her group's study results "could stimulate an exciting new line of research focused on preventing onset of illness through very early intervention in at-risk individuals."

"This fascinating study indicates that genes that increase risk for some psychiatric diseases may actually alter brain structure prior to birth," Gary Small, M.D., a professor of psychiatry at the University of California, Los Angeles, and a neuroimaging and Alzheimer's expert, said in an interview. "These findings point to the importance of developing interventions that exert their effects very early in the course of these conditions so that they can protect a healthy brain before neuronal damage becomes extensive."

The study was funded by the National Institutes of Health. PN

An abstract of "Common Variants in Psychiatric Risk Genes Predict Brain Structure at Birth" is posted at http://cercor.oxfordjournals.org/content/early/2013/01/02/cercor.bhs401.abstract.

Imaging Helps Predict Anxiety Patients Who May Benefit From CBT

Neuroimaging may prove useful for predicting which patients with social anxiety disorder will profit most from cognitive-behavioral therapy.

BY JOAN AREHART-TREICHEL

Neuroimaging may prove useful for predicting which patients with social anxiety disorder (SAD) are likely to gain the most benefit from cognitive-behavioral therapy (CBT), suggests a study reported in the January *JAMA Psychiatry* (formerly *Archives of General Psychiatry*).

The study was headed by Oliver Doehrmann, Ph.D., of the McGovern Institute for Brain Research at the Massachusetts Institute of Technology.

Doehrmann and his colleagues used fMRI imaging on 39 subjects with SAD to determine how their brains reacted when they were shown photos of angry or neutral faces. As the researchers explained, "Angry faces, relative to neutral faces, convey disapproval and are likely to evoke excessive fear responses and negative cognitions in patients with SAD. Also, the means to down-regulate these responses are learned during CBT."

After the study subjects had viewed the pictures, the researchers had them undergo 12 weekly group-based CBT treatment sessions. Finally the researchers evaluated whether the means in which the subjects' brains reacted to angry or neutral faces predicted whether the subjects would respond to CBT.

The researchers found that the responses shown during the brain imaging did help them determine which subjects would benefit most from CBT.

The subjects with greater brain activation in response to angry rather than neutral faces gained greater benefits from CBT, while subjects showing the reverse—greater activation for neutral than for angry faces—gained fewer benefits from CBT.

Sergey Ivanov

The researchers also found that combining the brain-imaging measures with information on clinical severity accounted for more than 40 percent of the variance in treatment response and substantially exceeded predictions based on clinical severity alone, which accounted for about 12 percent of the variance in treatment response.

"The results suggest that brain imaging can provide biomarkers that substantially improve predictions for the success of cognitive-behavioral interventions and more generally suggest that such biomarkers may offer evidence-based, personalized medicine approaches for optimally selecting among treatment options for a patient," Doehrmann and his team concluded.

Some of their results surprised them, though, they acknowledged. For example, when subjects reacted to angry faces, the areas of their brains that reacted were regions of the higher-order visual cortex—not the amygdala, which is the fear-processing center of the brain.

The study was funded by the National Institute of Mental Health, the German Research Society, and the Poitras Center for Affective Disorders Research. PN

An abstract of "Predicting Treatment Response in Social Anxiety Disorder From Functional Magnetic Resonance Imaging" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleId=1356542&utm_source=Silverchair.

CLINICAL & RESEARCH NEWS

ADHD Medications Linked To Lower Crime Rates

Medications used to treat attention-deficit/hyperactivity disorder appear to contribute to reduced criminal behavior in some individuals with that disorder.

BY JOAN AREHART-TREICHEL

A large Swedish population study has led to a provocative discovery regarding adults with attention-deficit/hyperactivity disorder (ADHD).

When individuals with that disorder used ADHD medications, their crime rates decreased.

The study was headed by Paul Lichtenstein, Ph.D., of the Karolinska Institute in Stockholm. The results of the study were published in the November 22, 2012, *New England Journal of Medicine.*

Using Sweden's linked population-based registers, which include unique personal identification numbers, Lichtenstein and his colleagues gathered information on approximately 26,000 adults with a diagnosis of ADHD, their medical treatment, and any criminal convictions in Sweden they may have had from 2006 to 2009.

Their analysis showed that more than half of the men had taken ADHD medications and that more than one-third had been convicted of at least one crime during the study period. They also found that two-thirds of the women had taken ADHD medications and that 15 percent had been convicted of at least one crime during the study period.

The researchers then focused on those subjects who had used ADHD medications and compared their crime rates while taking ADHD medications with their crime rates while not taking them. Data showed that when the men were taking their ADHD medications, their crime rate dropped by 32 percent. While the women were taking their ADHD medications, their crime rate dropped by 41 percent.

"These findings raise the possibility that the use of medication reduces the risk of criminality among patients with ADHD," the researchers concluded, adding that "[i]t is possible that pharmacologic ADHD treatment helps patients to better organize their lives or contributes to enduring changes at the neuronal level."

"Although some experts believe that for many individuals, crime is an ingrained (i.e., trait-like) behavioral pattern not amenable to medication-induced changes in 'state,' this study convincingly shows that ADHD treatment reduces the propensity of at least some individuals to commit crimes," Peter Roy-Byrne, M.D., a professor of psychiatry at the University of Washington, asserted in *Journal Watch Psychiatry.*

> "Treatment for ADHD markedly reduces comorbid disorders."

"We have found similar results in our work that shows that treatment for ADHD markedly reduces comorbid disorders," Joseph Biederman, M.D., a professor of psychiatry at Harvard Medical School and an ADHD expert, told *Psychiatric News.*

He and his colleagues conducted a 10-year prospective follow-up study of boys with ADHD. They found that those who had received ADHD medications were significantly less likely to subsequently develop anxiety disorders, major depression, conduct disorder, and oppositional defiant disorder compared with those who had the disorder but who had not received such medications. The findings appeared in the July 2009 *Pediatrics.*

The Lichtenstein study was funded by the Swedish Research Council, the Swedish Council for Working Life and Social Research, the Swedish Prison and Probation Services, the Wellcome Trust, and the U.S. National Institute of Child Health and Human Development. PN

An abstract of "Medication for Attention Deficit/Hyperactivity Disorder and Criminality" is posted at www.nejm.org/doi/full/10.1056.NEJMoa1203241.

ADHD With Bipolar Disorder May Be Distinct Illness

Attention-deficit/hyperactivity disorder in people with bipolar disorder may be a distinct familial entity and perhaps even a distinct disorder.

BY JOAN AREHART-TREICHEL

Attention-deficit/hyperactivity disorder (ADHD) plus bipolar disorder is a distinct familial entity and perhaps even a distinct disorder, a study reported in the January *Journal of Psychiatric Research* suggests.

The study was headed by Joseph Biederman, M.D., a professor of psychiatry at Harvard Medical School.

Biederman and his colleagues studied 401 children with bipolar disorder, ADHD, or both, as well as nearly 1,200 of their relatives. They found that when children had bipolar disorder alone, their relatives were also more likely to have bipolar disorder alone; when children had ADHD alone, their relatives were also more likely to have ADHD alone, and when children had bipolar disorder in addition to ADHD, their relatives were also more likely to have both disorders.

"The co-segregation findings suggest that ADHD plus bipolar disorder is a distinct familial entity and, perhaps, a distinct disorder," Biederman and his team said. "[And] the idea that ADHD comorbid with bipolar disorder is a distinct disorder is further supported by emerging neurobiological findings." For example, the gene that codes for the dopamine transporter has been linked with both ADHD and bipolar disorder.

Further studies addressing genetic association and neuroimaging of subjects with both bipolar disorder and ADHD "may yield important information regarding course, treatment, and the neurobiology of bipolar disorder plus ADHD to determine if this combined condition should be considered a distinct disorder," Biederman and his colleagues also noted.

The study was funded by the National Institutes of Health, the Heinz C. Prechter Bipolar Research Fund, the Massachusetts General Hospital Pediatric Psychopharmacology Council, and the Susan G. Berk Endowed Fund for Juvenile Bipolar Disorder. PN

An abstract of "Further Evidence That Pediatric-Onset Bipolar Disorder Comorbid With ADHD Represents a Distinct Subtype: Results From a Large Controlled Family Study" is posted at www.sciencedirect.com/science/article/pii/S002239561200235X.

Viewpoints

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group, and neither the chair nor co-chair of these groups should have any industry ties at all.

Anticipating these changes, over the last few years the APA Steering Committee on Practice Guidelines has devoted considerable effort to producing practice guideline development procedures that meet or exceed the IOM recommendations with regard to avoiding industry influences. None of the individuals involved in current or future guideline development efforts have any industry ties. This includes all members of the Steering Committee for Practice Guidelines and the Executive Committee for Practice Guidelines, all members of the current Psychiatric Evaluation guideline-writing group, all members of our systematic literature review group, and all members of the recently appointed and empaneled guideline writing group that will write an assortment of planned forthcoming guidelines. Part of the recommended process for guideline development involves obtaining public comment, and some individuals offering input may have industry relationships. We also anticipate that during guideline development, there may be a need for updated information on ongoing clinical trials or experts' perspectives on a specific topic. Such individuals may happen to have ties such as research grants with industry, which they will be asked to disclose as part of the commenting process. Furthermore, in line with IOM standards, only the guideline-writing group will write and determine the strength of official guideline recommendations.

Over the past decade, there has been substantial evolution in the national discourse and standards for addressing industry relationships in clinical practice guideline development. During the time that APA's practice guideline for the treatment of major depressive disorders was written, there was a rapid transition of views about industry ties and other potential conflicts of interest. Despite these shifts in standards for industry relationships, we took multiple steps to assure that treatment recommendations were not influenced by industry biases. We believe that we fully succeeded in that goal, and we stand behind the guideline as representing the best available evidence-based recommendations. The Association has also developed stringent policies and procedures to assure that forthcoming guidelines will meet IOM standards, continuing to assure that our practice guidelines are trustworthy and free of bias. PN

JOURNAL DIGEST

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Most clinical trials for Alzheimer's disease dementia involve patients whose caregiver is their spouse, possibly affecting trial outcomes.

BY LESLIE SINCLAIR

Alzheimer Dementia Trials Omit Patients Without Spouses

Clinical trials involving patients with Alzheimer's disease (AD) dementia can be particularly difficult to conduct, largely because they require the enrollment of both the patient and his or her caregiver. But can the relationship between the AD patient and the caregiver affect trial participation and outcomes?

Researchers based at the Mary Easton Center for Alzheimer's Disease Research in the Department of Neurology at the University of California, Los Angeles, recently performed a retrospective analysis of six Alzheimer's Disease Cooperative Study randomized clinical trials, evaluating the prevalence of study-partner type and the associations between study-partner type and trial outcomes. They found that more patients (67 percent) enrolled with spouses than with adult children (26 percent) or other caregivers (7 percent). Patients with spouse caregivers had a lower study dropout rate (25 percent) than those who had their adult children (32 percent) or other people (34 percent) as caregivers.

The researchers said their data do not explain why patients with nonspouse study partners were underrepresented. However, compared with spouses, adult-child caregivers were more likely to be working and living apart from the patient, increasing the logistical challenge to research participation. "Another possible reason is that trials typically require patients with mild severity and thus enroll young AD patients who, in turn, may be more likely to have spouses," they noted. They concluded that increased enrollment of AD patients with nonspouse caregivers may require additional recruitment and retention strategies.

Grill J, Raman R, Ernstrom K, et al. "Effect of Study Partner on the Conduct of Alzheimer Disease Clinical Trials." Neurology. 2012. December 12 [Epub ahead of print]. www.neurology.org/content/early/2012/12/19/WNL.0b013e31827debfe.abstract

HIV-Infected Smokers Lose More Years to Smoking Than to HIV

Smoking poses a greater risk to the life expectancy of a well-treated HIV patient than does HIV disease, a Danish study has found. After evaluating data on 2,921 HIV-infected patients and 10,642 controls, researchers at Copenhagen University Hospital concluded that in a setting where HIV care is well organized, and antiretroviral therapy is free, HIV-infected smokers lose more life-years to smoking than to HIV-related diseases.

Their findings showed that excess mortality of smokers is tripled and the population-attributable risk of death associated with smoking is doubled among HIV patients, compared with the background population. "Owing to the high proportion of smokers among HIV patients, the population-attributable risk of death associated with smoking was large, which underscores the importance of prioritizing interventions for smoking cessation in the care of HIV patients, as well as in the general population," they said.

Study subjects came from the Danish HIV Cohort Study, a population-based nationwide cohort study of all HIV-infected individuals treated at Danish HIV centers after January 1, 1995. The control population came from the Copenhagen General Population Study, a prospective study of a cohort of individuals randomly selected from greater Copenhagen.

Helleberg M, Afzal S, Kronborg G, et al. "Mortality Attributable to Smoking Among HIV-1-Infected Individuals: A Nationwide, Population-Based Cohort Study." Clin Infect Dis. 2012. December 18 [Epub ahead of print]. www.ncbi.nlm.nih.gov/pubmed/23254417

Psychiatric Patients More Likely to Die of Cancer

Psychiatric patients are for the most part no more likely than the general population to develop cancer, but are more likely to die of it. Australian researchers recently performed a population-based record-linkage analysis that compared psychiatric patients with the general Western Australia population to determine why. Mental health records were linked with cancer registrations and death records from January 1, 1988, to December 31, 2007, in Western Australia.

Their findings were alarming. Cancer incidence was lower in psychiatric patients than in the general population in both males and females, although mortality was higher and the proportion of cancer with metastases at presentation was significantly higher in psychiatric patients. Despite this, psychiatric patients had a reduced likelihood of surgery, especially resection of colorectal, breast, and cervical cancers, and they received significantly less radiotherapy for breast, colorectal, and uterine cancers, as well as fewer chemotherapy sessions.

"These results could suggest inequitable access to appropriate care, especially given that reduced access to treatment persisted after controlling for the presence of metastases," wrote the researchers. "The results may indicate action required to decrease inequity and thus improve health outcomes of psychiatric patients. They also pointed to the need for cancer screening and treatment for psychiatric patients similar to those that exist for cardiovascular and diabetes care for these patients.

Kisely S, Crowe E, and Lawrence D. "Cancer-related Mortality in People With Mental Illness." Arch Gen Psychiatry. 2012. December 17 [Epub ahead of print]. http://archpsyc.jamanetwork.com/article.aspx?articleid=1485447

Workplace Bullying Leads to Psychotropic Medication Use For Victims and Observers

Finnish researchers reported that people who are bullied at work, or even those who simply observed bullying taking place at work, are more likely to take psychotropic medication at some point after the bullying occurs. The researchers linked data that detailed purchases of prescribed reimbursed psychotropic medication from the Finnish Social Insurance Institution register with a survey of the employees of the city of Helsinki, Finland, who were 40 to 60 years old (n=6,606, 80 percent women). The researchers noted that the city of Helsinki is the largest employer in Finland, and there are around 200 different non-manual and manual occupations. After adjusting for age and prior medication use among both women and men, they found that being bullied in the workplace and observing bullying in the workplace were associated with subsequent psychotropic medication use. "These findings confirm those from previous cross-sectional studies and, in particular, corroborate associations found between workplace bullying and self-reported mental health," the researchers wrote. The study was funded by the Academy of Finland.

Lallukka T, Haukka J, Partonen T, et al. "Workplace Bullying and Subsequent Psychotropic Medication: A Cohort Study With Register Linkages." BMJ Open. 2012. December 12 [Epub ahead of print]. http://bmjopen.bmj.com/content/2/6/e001660.full

Some Cancer Survivors Report Poorer Mental, Physical Health

Data from the 2010 National Health Interview Survey show that cancer survivors experience poorer physical and mental health than the general population, and researchers at the Wake Forest School of Medicine say interventions are needed to improve survivor health at a population level. The researchers identified 1,822 cancer survivors and a control group of 24,804 adults with no cancer history from the survey and used the PROMIS Global Health Scale to assess health-related quality of life (HRQOL). Poor physical and mental HRQOL were reported by 24.5 percent and 10.1 percent of survivors, respectively, compared with 10.2 percent and 5.9 percent of adults without a history of cancer. "This represents a population of approximately 3.3 million and 1.4 million U.S. survivors with poor physical and mental HRQOL," wrote the researchers. They noted that the HRQOL varied according to the type of cancer experienced: Survivors of breast or prostate cancer or melanoma reported scores similar to adults without cancer. Survivors of cervical, colorectal, hematologic, short-survival, and other cancers had worse physical HRQOL. Cervical and short-survival cancer survivors reported worse mental HRQOL. "Not all survivors report they are thriving," wrote the researchers, who urged that easily implemented interventions be pursued for high-risk groups.

Weaver K, Forsythe L, Reeve B, et al. "Mental and Physical Health-Related Quality of Life Among U.S. Cancer Survivors: Population Estimates From the 2010 National Health Interview Survey." Cancer Epidemiology Biomarkers and Prevention Online First. 2012. October 30 [Epub ahead of print]. www.ncbi.nlm.nih.gov/pubmed/23112268

Scully

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have to say, but what always drove me was the idea that someone might say, 'if you want to know what a great membership organization looks like, go look at APA,' " he said.

'APA Today Is Sound and Stable'

"I hope that we have reaffirmed that APA is a member-centered organization—data driven but member oriented—that looks after the entire profession of psychiatry and serves as a voice for its members," Scully told *Psychiatric News*. "APA's greatest strength has always been its staff, and I've been honored to lead them. It's to the credit of the APA staff that I think we can confidently say, even if there is always room to improve, that APA today is sound and stable."

Scully came to the medical director's office from the University of South Carolina School of Medicine, where he had been the Alexander G. Donald Professor and chair of the Department of Neuropsychiatry and Behavioral Science. But he was not new to APA, having served as a deputy medical director of APA and director of its Office of Education from 1992 to 1996.

Past APA President John Oldham, M.D., told *Psychiatric News* that APA and its members can be grateful for Scully's presence in the medical director's office.

"As CEO and medical director of APA, Jay has provided superb leadership," said Oldham. "I could not have succeeded in my year as president without Jay as an invaluable partner, who was always available. Behind the scenes and in front of the scenes, Jay has been the steady voice of APA—through good times and when times have been tough. He is widely recognized and respected in the entire field of medicine, and we owe him a huge debt of gratitude for all that he has done for APA."

When Scully took over APA, the organization was facing serious financial challenges, not different from those facing the nation as a whole today. As Scully put it simply, "We were spending more than we were taking in."

So fiscal discipline was a first order of business. "I told staff that we needed to be clear about how we spend the members' money," he said. "We dedicated ourselves to giving senior management the best possible information about where the organization was in terms of revenue so we could get the most out of the dollars we were spending."

The nationwide financial crisis of 2008 was a temporary setback, and Scully noted that the loss of an exclusive malpractice insurance offering that same year resulted in a loss of members. "It may be slow, but I am confident we will get those member numbers back up," he said.

Because of subspecialization and other issues, membership has been a prevailing concern for all medical membership societies, and APA is no exception. "It's an ongoing concern that we have the right balance of dues and member services, and that's something we are always looking at," he said. "Along with the wider society, we have an aging membership, and we need to think about a younger generation of tech-savvy psychiatrists. What do they need out of a medical society that we can provide—even if it means doing things differently from how we've done them in the past?"

Communications Upgrades Enacted

"The world of communications has radically changed during my tenure—that's not specific to APA but has been a worldwide phenomenon," he continued. "APA has gotten more technologically oriented with our communications, our electronic journals have more information than the printed versions, and the new *DSM-5* will have electronic components for members using electronic health records. And we do more and more online webinars for our members."

James Tyll

James H. Scully Jr., M.D., made numerous trips to Capitol Hill during his years as APA medical director and CEO. Above, he joins in a discussion last September organized by the U.S. Senate Special Committee on Aging on implementing the Physician Payments Sunshine Act.

The electronic revolution is not the only storm that brewed outside APA's walls. Possibly the single most important issue to become prominent during Scully's tenure—one that has convulsed the entire field of medicine—is public concern about financial relationships between medicine and the pharmaceutical and device industries.

In the popular media and on Capitol Hill—where Sen. Charles Grassley (R-Iowa) undertook a series of hearings on the topic—psychiatry was sometimes singled out. "We have always tried to be transparent," Scully said. "And what was frequently lost is that we were often commended by external accrediting agencies for the way we have managed our relationships with industry."

But it was clear that professional medical societies of all types were in for change. In April 2009 Scully co-wrote an article in the *Journal of the American Medical Association* titled "Professional Medical Associations [PMAs] and Their Relationships With Industry: A Proposal for Controlling Conflict of Interest," arguing that integrity and the maintenance of public trust were of overriding importance. "To maintain integrity, sacrifice may be required. Nevertheless, these changes are in the best interest of the PMAs, the profession, their members, and the larger society," the article concluded.

'No Other Group Does What We Do'

That year APA eliminated industry-supported symposia at its annual meetings, a move that was not without financial pain. "The Board and I agreed that we needed to make some changes even if they entailed real cost to us in lost revenue," Scully told *Psychiatric News*. "Part of our core mission is to make sure our members get the highest-quality information as a part of their continuing medical education. Having a relationship with industry to obtain this is not core."

There were real and lasting victories on Capitol Hill too—most notably the historic passage of the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 and the elimination of discriminatory copayments for mental health treatment in the Medicare program. APA's leadership in those legislative efforts was critical, as was the organization's partnership with the AMA; the latter partnership has resulted in former APA Assembly Speaker Jeremy Lazarus, M.D., being only the third psychiatrist president of the AMA in its history.

> "I hope that we have reaffirmed that APA is a member-centered organization. . . that looks after the entire profession of psychiatry and serves as a voice for its members."

As for what's next for APA's retiring medical director, Scully says he's keeping his options open. He'll return to his home state of South Carolina, where he may serve as voluntary faculty at the University of South Carolina School of Medicine; and he looks forward to a term as president of the American College of Psychiatrists.

Scully will leave behind an APA stronger than he found it when he became medical director 11 years ago, and one that is poised to face the future.

"We are the voice of psychiatry," he said. "No other group does what we do. If APA is not successful, psychiatry will not be successful." PN

Wisdom Speaks: Advice for Young Psychiatrists

As a former director of APA's Department of Education and a former chair of the Department of Psychiatry at the University of South Carolina School of Medicine, the "home turf" of outgoing APA Medical Director and CEO James H. Scully Jr., M.D., is medical education.

So what's his advice to young psychiatrists in training or just starting a career?

For starters, be confident about the future. "All of the funding and systems issues as health care reform rolls forward will settle out, and psychiatry will be valued," he told *Psychiatric News*. "My advice is to learn from your craft and spend time to be an expert. We are short in every area—general, child, geriatric, and addiction psychiatry."

And don't become isolated. "Be involved with your professional society," Scully said. "Don't burn out—take care of yourself so you can take care of others."

And finally, "It's an immensely exciting field, and it can be great fun," he said. "The ability to know your patients, hear their stories, and understand their uniqueness is special. You can do great work with people and help them change and lead much more healthy lives."

Physician Suicide

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their system," she said. "But for physicians, there is a lot of stigma associated with treatment for mental illness. In many states, a mental health disorder in a physician is still considered an impairment, just as substance or alcohol abuse might be."

One difference Gold and her colleagues identified between physicians and nonphysicians was the preferred method: Both groups chose firearms as the most common method, but for physicians, poisoning was next, followed by blunt trauma, and asphyxia, which included hanging. For nonphysicians, asphyxia was the second most common method of choice, then poisoning, and lastly blunt trauma.

They were able to identify psychosocial stressors that differed between physicians and nonphysicians. Having a job problem contribute to the suicide predicted an increased likelihood of being a physician, while the death of a friend or family member or a crisis in the last two weeks of life were significantly associated with being a nonphysician.

Gold and her colleagues theorized that "the reduced risk of a recent loss or crisis and the increased risk of a job problem may reflect physician experience dealing with death and loss but an inability to cope with problems related to their identity as a physician.... For someone whose work helps to define his/her personal and professional identity, a crisis in a work situation might feel more threatening than for someone whose personal identify was less reliant on work satisfaction."

Prior studies, they noted, have found a correlation between patient demands, role conflicts, lack of control over working conditions, degrading experiences or harassment, and conflicts with coworkers as significant risks for suicidal ideation among physicians.

Gold and her colleagues hope their work will lead to programs for physicians addressing common stressors, but admit there are many obstacles to such programs. "There are multiple barriers to appropriate help-seeking, diagnosis, and treatment of mental health problems among physicians due to stigma and possibly lack of social recognition of the problem. Physician knowledge of pharmaceuticals, dosing, and lethality, as well as greater access to medications with lethal potential, present a further challenge in designing an effective plan to reduce physician suicide," they concluded.

The authors reported no specific source of funding for the study. PN

An abstract of "Details on Suicide Among U.S. Physicians: Data From the National Violent Death Reporting System" is posted at http://www.ghpjournal.com/article/S0163-8343(12)00268-X/abstract.

What Is the National Violent Death Reporting System?

The National Violent Death Reporting System (NVDRS) is a state-based surveillance system implemented in 2002 by the Centers for Disease Control and Prevention (CDC). States that are funded for NVDRS operate under a cooperative agreement with the CDC to which all violent deaths are voluntarily reported. NVDRS funded six states initially. In 2006, the CDC received funding to expand the system to 17 states, with an eventual goal of including all 50 states, all U.S. territories, and the District of Columbia.

The system links data from law enforcement, coroners and medical examiners, vital statistics, and crime laboratories. NVDRS defines a death due to violence as "a death resulting from the intentional use of physical force or power against oneself, another person, or against a group or community." NVDRS collects information about homicides, suicides, deaths by legal intervention—excluding executions—and deaths of undetermined intent. In addition, information about unintentional firearm injury deaths (that is, the individual did not intend to discharge the firearm) is collected, although these deaths are not considered violent deaths by the above definition. Deaths are included if their underlying causes (ICD codes) are included in these categories.

NVDRS is incident-based, and each record contains data on all victims and alleged perpetrators associated with a given incident. Multiple victims and/or suspects are determined for inclusion into a single incident record by the timing of the violent injuries, rather than the timing of the deaths, and include all persons with fatal injuries occurring within 24 hours of the first fatal injury, along with source documents indicating a clear link among the deaths. Each incident record includes information about victims, suspects, the relationship between the victim and the suspect, circumstances surrounding the death, and the method of injury.

The CDC cautions users of the database that the data it contains cannot be generalized to the entire U.S. population. Changes or fluctuations in rates generated by the database could be the result of demographic or socioeconomic fluctuations in the individual states as compared to the entire U.S. population.

Choline

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to the first stimulus; a smaller ratio indicates an inhibition of the cerebral response to the repeated stimulus and serves as a proxy for healthy development of sensory gating and attention.

Seventy-six percent of the infants whose mothers received choline supplementation were found to have intact cerebral inhibition according to the electrophysiological test, compared with just 43 percent of the infants whose mothers took placebo.

Moreover, a genotype associated with schizophrenia known as CHRNA7 was correlated with diminished P50 inhibition in the infants of the placebo group, but not in the infants of the choline group.

American Journal of Psychiatry (AJP) Editor in Chief and senior author of the study Robert Freedman, M.D., told *Psychiatric News* the findings suggest that dietary supplementation with choline may improve brain function in infants who are genetically at risk for schizophrenia.

"The hypothesis that improving prenatal brain development might decrease schizophrenia in later life merges decades of clinical observation of infants who later developed schizophrenia with recent findings that many genes that increase risk for schizophrenia have roles in fetal brain development," Freedman said. "It is fortunate that the developmental effects of one gene variant associated with schizophrenia appear to be lessened in newborns by choline, a common nutrient for which many women are deficient. This step is hopefully one of many, with others needed to track these infants over time and to determine the effects of populationwide prenatal interventions on the ultimate development of schizophrenia as well as other neurodevelopmental psychiatric disorders."

In an editorial appearing in the March issue of *AJP,* in which the study will be published in print, psychiatrist Judith Rapoport, M.D., of the Child Psychiatry Branch at the National Institute of Mental Health, noted that prevention through maternal diet during pregnancy has been successful on rare previous occasions, most notably for neural tube defects, which are best prevented by supplementing the maternal diet with folic acid. "While [the study authors] acknowledge that their choline study is not powered or planned to address prevention of schizophrenia, it represents a landmark proof of concept showing that such an approach might be possible," she said.

The study was supported by the Institute for Children's Mental Disorders, the Anschutz Family Foundation, and grants from the National Institutes of Health and by the American Academy of Child and Adolescent Psychiatry Elaine Schlosser Lewis Fund. PN

"Perinatal Choline Effects on Neonatal Pathophysiology Related to Later Schizophrenia Risk" is posted at http://ajp.psychiatryonline.org/AJPInAdvance.aspx.

Key Points

- Choline enhances brain function related to "cerebral inhibition," which is crucial to sensory gating and attention.
- Infants who received dietary supplementation of choline were more likely to have intact cerebral inhibition than those who received placebo.
- A genotype associated with schizophrenia was correlated with poorer cerebral inhibition in the placebo-treated group but not in the group receiving choline.

Bottom Line: Perinatal dietary supplementation with choline may enhance healthy brain development, especially with regard to sensory gating and attention, which are important in risk for schizophrenia.

Meth Use

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symptoms and that the dose-response effect remained.

"Given the widespread use of methamphetamine globally, greater awareness is needed about the potential effect of this drug on mental health," the researchers said. "Better evidence is needed on how to manage symptoms of methamphetamine-induced psychosis, and evidence-based treatments for methamphetamine dependence need to be more broadly implemented to curb the high levels of use that induce psychotic symptoms. Although psychotic symptoms appeared to be largely circumscribed to periods of methamphetamine use, the long-term effect of methamphetamine use on a person's vulnerability to psychosis needs to be better understood." PN

An abstract of "Dose-Related Psychotic Symptoms in Chronic Methamphetamine Users: Evidence From a Prospective Longitudinal Study" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=1555603.

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Faculty members are employed by a number of health care organizations in the metro area, but report directly to the Chair regarding their academic appointment and service to the Department and the School of Medicine. The ability to work collaboratively with community partners in fulfilling the clinical, teaching and research missions of the department and expanding opportunities for these activities will be a crucial skill. The Center for Behavioral Medicine serves a diverse population and maintains partnerships with a wide array of provider systems in the community. The Medical Director provides leadership in fostering these important clinical and academic linkages. UMKC is an equal access, equal opportunity, affirmative action employer that is fully committed to achieving a diverse faculty and staff. Applications will be accepted until the position is filled.

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Universal Health Services, Inc. (UHS) www.uhsinc.com is the largest facilities based behavioral health provider in the country. Our nearly 200 facilities operate independently and develop programs that satisfy the needs of each community. Our services touch more than 350,000 lives each year - from youth and adult programs to dedicated services for the military.

For more information about all locations and positions contact: Joy Lankswert, UHS In-house Physician Recruitment @866-227-5415 ext: 222 or email joy.lankswert@uhsinc.com. See all UHS positions and facilities at www.physicianpracticeopportunities.com.

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TELEPSYCHIATRIST

Pathways, Inc., a pioneer in telepsychiatry services in Maryland is seeking a licensed, board certified/board eligible Psychiatrist for our growing outpatient clinic. We will assist the interested applicant in arranging for a secure video-conferencing connection and will structure compensation to cover its cost. For excellent service interface we utilize a web-based EMR with e-prescribing capability. We are interested in adding up to 20 hours of psychiatric time so if you are interested in providing quality treatment from your existing location 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.

Psychiatrists/APNs: Join the Telehealth Revolution. Earn $145-$200/hr doing Telepsychiatry from home or office. Fully supported. No special techskills needed. Join our nationwide network of professionals connecting to rural facilities with Forefront TeleCare. Six hrs/wk-full time. Contact: Merritt Widen,CEO 510-201-0190 or send CV to Merritt@ForefrontTelcare.com.

Psychiatrists Wanted for Medical Director Roles

Magellan Behavior Health is seeking to hire board certified psychiatrists for Medical Director positions in our Care Management Centers (CMC). Magellan is a clinically-driven and physician-led company where our physician leaders develop the clinical/medical mission of the CMC and have a direct impact on the health outcomes and quality of care in the region. There are full and part-time opportunities available for psychiatrists with or without managed care experience. Relocation is available for full-time positions. Current openings include:

- Des Moines, IA – Medical Director CMC
- Worcester, MA– Medical Director CMC
- San Diego, CA – Medical Director CMC
- New Jersey – Part-time Associate Medical Director
- Georgia – Part-time Associate Medical Director

Psychiatrists interested in exploring these opportunities should contact Kevin Palisi at (860) 507-1955 or email kjpalisi@magellanhealth.com. Apply online at http://www.magellanhealth.com.

ALABAMA

Horizon Health seeks a **Medical Director** for a new Geriatric Inpatient Psychiatric Program in **Baldwin County.** Excellent practice opportunity and income for 3 day per week coverage, while living on beautiful Gulf Coast. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

CALIFORNIA

UC DAVIS SCHOOL OF MEDICINE DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Health Sciences Assistant/Associate Clinical Professor – Jail Psychiatric Services. The University of California, Davis, Department of Psychiatry and Behavioral Sciences is recruiting for a Health Sciences Assistant/Associate Clinical Professor in the clinician/teaching series to serve as teaching attending at the Sacramento County Jail. The Jail Psychiatric Service provides inpatient and outpatient clinical services at the Sacramento County Jail. General psychiatry residents and medical students rotate at these sites. Interest and experience in teaching and supervision of medical students, residents, and other mental health professional is highly desirable. The successful candidate should be board eligible or certified in general psychiatry and be in possession of or eligible for a California Medical license. The successful candidate will provide group and individual supervision of clinical cases for general psychiatry residents, psychology fellows, medical students and other mental health professionals (including timely and appropriate evaluation of trainee performance) as well as have the opportunity to lead small group seminars and case conferences. The Department provides a stimulating teaching and research academic environment and serves a culturally diverse population. See www.ucdmc.ucdavis.edu/psychiatry.

For full consideration, applications must be received by March 31, 2013. However, the position will remain open until filled through May 31, 2013.**Interested candidates should email a curriculum vitae and letter of interest in response to Position #PY-02R-13 to Nicole Prine at Nicole.prine@ucdmc.ucdavis.edu.** For more information concerning these positions, please contact the search committee chair, Dr. Robert Hales at rehales@ucdavis.edu. In conformance with applicable law and University policy, the University of California, Davis, is an equal opportunity/affirmative action employer.

http://www.ucdmc.ucdavis.edu/psychiatry

Adult In-Patient, Outpatient Adult and Child psychiatric positions available with Butte County Behavioral Health Department. Both contracted and full/half time positions. $150/hour for contracted positions. We are a HPSA/NHSC-designated County. Please contact Dr. Carolyn Kimura, Medical Director, at 530-891-2850.

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March 15	March 1

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CLASSIFIEDS

Adult Psychiatrists

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

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

An Outpatient Adult Psychiatrist is needed for Stanislaus County Behavioral Health & Recovery Services, in the Central Valley less than two hours from San Francisco and Yosemite. Recovery-oriented treatment provided in a multidisciplinary setting. Excellent salary scale with steps starting from 179K to 217K; additional 5% differential for board certification. No call requirements at this time. Full benefit package including medical, vision/dental, vacation, sick time. Excellent retirement package with deferred comp. plan avail.

Fax CV to Uday Mukherjee, MD at
(209) 525-6291 or
Email: umukherjee@stanbhrs.org.

UC DAVIS SCHOOL OF MEDICINE DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Health Sciences Assistant/Associate Clinical Professor – Outpatient Clinic. The University of California, Davis, Department of Psychiatry and Behavioral Sciences is recruiting for two Health Sciences Assistant/Associate Clinical Professors in the clinician/teaching series to serve as teaching attendings at one of the Sacramento County clinics staffed by UC Davis Faculty. General psychiatry residents and medical students rotate at these sites. Interest and experience in teaching and supervision of medical students, residents, and other mental health professional is highly desirable. The successful candidate should be board eligible or certified in general psychiatry and be in possession of or eligible for a California Medical license. The successful candidate will provide group and individual supervision of clinical cases for general psychiatry residents, psychology fellows, medical students and other mental health professionals (including timely and appropriate evaluation of trainee performance) as well as have the opportunity to lead small group seminars and case conferences. The Department provides a stimulating teaching and research academic environment and serves a culturally diverse population. See www.ucdmc.ucdavis.edu/psychiatry.

For full consideration, applications must be received by March 31, 2013. However, the position will remain open until filled through May 31, 2013. **Interested candidates should email a curriculum vitae and letter of interest in response to Position #PY-03R-13 to Nicole Prine at Nicole.prine@ucdmc.ucdavis.edu.** For more information concerning these positions, please contact the search committee chair, Dr. Robert Hales at rehales@ucdavis.edu. In conformance with applicable law and University policy, the University of California, Davis, is an equal opportunity/affirmative action employer.

http://www.ucdmc.ucdavis.edu/psychiatry

COLORADO

Horizon Health seeks a **Medical Director** and **Attending Psychiatrist** for a new 22-bed Senior Behavioral Health program at our client hospital **Exempla Lutheran Medical Center** in **Wheat Ridge, CO.** Excellent practice opportunity and income. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com. EOE

CONNECTICUT

Adult/ Child Psychiatrist
Fairfield, CT

Group Psychiatry practice is seeking a full-time Psychiatrist. Excellent salary and benefits. Email CV to:doctorbeach52@gmail.com or fax to Attn: Melissa B. 203-255-3126.

FLORIDA

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

GEORGIA

Geriatric Psychiatrist

WellStar Medical Group is seeking Board Certified Psychiatrist with Geriatric Fellowship training for full-time position. Will provide services in Gero Psych Unit at WellStar Cobb Hospital, located in Austell, northwest of Atlanta, GA. Competitive salary with comprehensive benefit package.

To apply please do online application www.wellstarcareers.org or contact 770-792-7539 for additional information.

ATLANTA: General & Child Psychiatrists for Staff Positions - Inpatient OR Residential Treatment settings. Hospital Medical Director – Inpatient & Partial Services. **MOULTRIE:** General/Addiction Psychiatrist: Outpatient & Inpatient Services. **SAINT SIMONS:** General Psychiatrist – Inpatient & Partial services. All positions offer salary, benefits, bonus opportunities. Full time & Part-time position options. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

PSYCHIATRIST

New Horizons Community Service Board in Columbus, Georgia is seeking an Adult Psychiatrist for its Outpatient/Court Services programs. This growing community offers a pleasing climate and is situated within a short distance to Atlanta and the Gulf Coast. The qualified applicant will possess or be eligible for a valid physician's license from the state of Georgia, have completed a three-year residency in an accredited facility and be board eligible or board certified. Excellent salary with a comprehensive benefits package. Interested parties should send their curriculum vitae to:

Shannon Robertson
srobertson@newhorizonscsb.org
706/317-5001
706/317-5004 (Fax)

ILLINOIS

North Shore practice of Child Psychiatrists, Psychologists and Social Workers is seeking a part time adult/adolescent psychiatrist. Built in patient base from recently relocating psychiatrist. Very busy practice with numerous referral bases. No in-patient responsibilities. Applicant must be Board Eligible. Flexible hours and great work environment. Potential for full time exists. Please fax resume to Michael Greenbaum, M.D. at 847-680-3832 or e mail to blindquist@counselingconnections.net. Please see website for more information www.counselingconnections.net.

CHICAGO: Child Psychiatrist – Inpatient & Residential Treatment. Salary & benefits. Full or part-time Monday-Friday schedules. Contact Tiffany Crawford, In-house recruiter @ 866-227-5415 OR email tiffany.crawford@uhsinc.com.

Staff Psychiatrist: Provide direct patient care services and provide a liaison between the medical staff, clinical staff, administration and employees of the psychiatric unit and outpatient clinics established by Hospital. Requd: MD (Psychiatry); valid IL license to practice; board eligible or certified (Psychiatry); must live within 30 min commute of OSF Saint Elizabeth Medical Center. Inquiries: Sue Swong, Physician Recruiter, OSF Saint Elizabeth Med Ctr, 1100 East Norris Drive, Ottawa, IL 61350. MUST APPLY ONLINE at www.osfsaintelizabeth.org.

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www.MentalHealthChicago.com wants you to practice with us in the Chicago suburbs. BC/BE psychiatrist for inpt/PHP/consults/outpt/detox/clinical research/pain control/full or part time. Some call. IC status lets you design your own pension and benefits plan. Keep more of what you earn. Upwards of 300K for those willing to work. (847) 895-4540/c.v. to ASEN@mentalhealthchicago.com.

KENTUCKY

One Hour from Lexington!

Horizon Health seeks a Psychiatrist for our 10-bed Senior Adult, and 10-bed Adult, inpatient Behavioral Health programs our client hospital **St. Claire Regional Medical Center in Morehead, KY.** Experience with geriatric population preferred. Excellent salary, benefits and practice opportunity. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com. EOE.

HOPKINSVILLE (Nashville area commute) - Inpatient & partial programs. Staff Psychiatrist. Top salary, benefits & bonus compensation plan. **Fulltime or Part-time.** Contact Will DeCuyper, In-house recruiter @ 866-227-5415 OR email will.decuyper@uhsinc.com.

MARYLAND

FORENSIC PSYCHIATRIST

Springfield Hospital Center in Sykesville, MD is accepting applications for a Forensic Psychiatrist. Eligible candidates must have board certification including added qualifications in forensic psychiatry (or equivalent). Duties include pretrial evaluations of competency to stand trial and criminal responsibility, competency restoration, risk assessment, and training of residents and students. Please forward a CV and inquiry to Erik Roskes, MD, Director, Forensic Services, Springfield Hospital Center, by fax (410.970.7105) or email (erik.roskes@maryland.gov).

POSITION AVAILABLE — PSYCHIATRIST, F/T or P/T. Private CMHC on beautiful Eastern Shore of Maryland in Dorchester County. NO ON CALL. Strong professional clinical and support staff. Great work environment. Contact Medical Director, Donna Beitel, MD, PO Box 1103, Cambridge, MD 21613-1103 or marshyfam@DMV.com.

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 **Paramjit Agrawal, M.D., Clinical Director, SHC, 6655 Sykesville Road, Sykesville, MD 21784. For questions, call (410)970-7006 or e-mail paramjit.agrawal@dhmh.state.md.us.** EOE

CLASSIFIEDS

PSYCHIATRIST/MEDICAL DIRECTOR

BE/BC Child/Adolescent Psychiatrist/ Medical Director needed 20-40 hours a week for outpatient community mental health facility on Maryland's scenic Eastern Shore, one hour, 15 minutes from Baltimore-Washington area. The clinic is located in a Professional Shortage Area, is a National Health Service Corps site and is eligible for loan repayment. Send resume/ vitae with cover letter to Michael Campbell. LCSW-C, Director, Caroline Co. Mental Health Clinic, P.O. Box 10 Denton, Md. 21629, phone 410-479-3800, ext. 117, fax 410-479-0052 or e-mail mike.campbell@maryland.gov - EOE.

SHEPPARD PRATT HEALTH SYSTEM

GERIATRIC PSYCHIATRIST/ NEUROPSYCHIATRIST WITH RESEACH INTEREST SHEPPARD PRATT PHYSICIANS, P.A. TOWSON, MARYLAND

Psychiatrist with prior experience in geriatric psychiatry and/or neuropsychiatry is sought for an exciting position that combines the best of inpatient psychiatry, private practice and academic psychiatry. Sheppard Pratt Health System, one of the top 10 psychiatric health systems in the country, is seeking an applicant to join a group of physicians that focuses on the treatment of patients with cerebrovascular and neurodegenerative diseases. This position would be based in the Memory Clinic of the Neuropsychiatry Program, but would be coupled with inpatient work to satisfy a wide range of personal interests and compensation requirements. The position has great potential for leadership responsibilities. Elements of the Program are grant-supported, so there are opportunities for academic work including research. Extra board certifications, presentations in meetings, and scholarship in general are strongly encouraged. There are also opportunities for teaching and training of residents. The Neuropsychiatry Program is located on the historic Towson campus of Sheppard Pratt Health System, just north of Baltimore, Maryland.

Qualified candidates must possess a current license to practice in Maryland at the time of appointment and be Board certified. Fellowship training or post-Board experience in Geriatric Psychiatry or Neuropsychiatry is highly desired. Sheppard Pratt offers a generous compensation package and comprehensive benefits and is an equal opportunity employer.

If you would like to explore this opportunity, please contact our Director for Professional Services, Ms. Kathleen Hilzendeger at 410 938-3460, email khilzendeger@sheppardpratt.org.

MASSACHUSETTS

PSYCHIATRIC ATTENDING POSITION AVAILABLE AT MARLBOROUGH HOSPITAL, MEMBER HOSPITAL OF UMASS MEMORIAL HEALTH CARE

The Department of Psychiatry at UMass Memorial Health Care is actively seeking an Attending Physician for its affiliated program at Marlborough Hospital. The position primarily involves the provision of inpatient psychiatric care, leading an interdisciplinary treatment team and participating in medical student education on the service. The unit at Marlborough involves 0.8 FTE, although full time employment is available for interested candidates. The ideal candidate will possess strong clinical abilities and a commitment to providing patient centered care in a collaborative environment. The physician will receive a highly competitive benefits package as part of our UMass Memorial Group Practice and academic appointment at the medical school commensurate with experience.

For consideration and/or additional details, or to learn about other opportunities affiliated with UMass, please send your CV and letter of introduction to: psychiatryrecruitment@umassmemorial.org.

Applicants are also encouraged to visit the UMass Department of Psychiatry's web site: www.umassmed.edu/psychiatry.

CAMBRIDGE HEALTH ALLIANCE: Outpatient Child/Adolescent Psychiatry Position

Cambridge Health Alliance, Division of Child and Adolescent Psychiatry, Harvard Medical School. Community based outpatient position in collaboration with local and regional agency partners. Role involves direct psychiatric care and consultation with multidisciplinary clinical teams at agency sites. Part time, 20-30 hours/ week. Position also includes opportunities for teaching child psychiatry fellows, general psychiatry residents, medical students, and other trainees as well as participation in academic department activities. 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 and/or bicultural abilities are desirable. Interest and experience with dual diagnosis and/or substance use disorders preferred. 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 Joel Goldstein, MD, Dept. of Psychiatry, 1493 Cambridge Street, Cambridge, MA 02139. Fax 617-665-1204. Email: JoGoldstein@challiance.org** (email preferred).

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

Please send letter of interest and cv to: Joseph D'Afflitti, M.D., Chair, Department of Psychiatry, Mount Auburn Hospital, 330 Mount Auburn Street, Cambridge, MA 02138; tel: 617 499-5054; email:jdafflit@mah.harvard.edu.

Berkshire Health Systems

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.

CAPE COD HEALTHCARE

We're taking good care of you.™

Cape Cod Healthcare Out-Patient Psychiatrist Opportunity

Cape Cod Healthcare (www.capecodhealth.org) in Hyannis, MA is looking for a BC/BE psychiatrist. This opportunity allows the applicant to work weekdays-only in an outpatient setting and then enjoy the beaches, recreational activities, and beauty of Cape Cod each weekend. Boston and Providence are both an hour's drive away. Responsibilities include performing new evaluations and monitoring medications at the largest outpatient clinic on Cape Cod. Competitive salary and benefit package. For additional information, email Jolia Georges, Director of Physician Recruitment, jgeorges@capecodhealthcare.org, or call 508-862-5481.

MISSISSIPPI

Horizon Health seeks a **Medical Director** for a 19-bed Adult Inpatient Psychiatric Program in **Northern MS.** Well established, busy program with full complement of support staff and administration. $200K+ Salary, Full Benefits, CME, Relocation and more. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

MISSOURI

One of the Midwest's Best Kept Secrets – St. Joseph, MO – Close to Kansas City – Wonderful city to live and work, great schools, 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 and outpatient; Call 1:5. Offering attractive student loan repayment if needed. Come join our incredible behavioral health team on this growing psych service. **This is a "must see" opportunity if you looking for a quality Psychiatry program; and the area is wonderful!** 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 a PSYCHIATRIST to join our faculty in Lebanon, NH.

The core position involves providing clinical services to patients of the inpatient psychiatric unit, staffing the partial hospitalization program, providing ECT and some outpatient evaluations and follow-ups. The successful candidate will be a skilled psychiatrist who works well on a team. The ability to interact effectively with physicians and nurses from other medical center services is essential. This physician will have opportunities to teach medical students and residents.

Candidates should be board certified or eligible in 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 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.

CLASSIFIEDS

Department of Psychiatry
Faculty Positions
GEISEL SCHOOL OF MEDICINE
at DARTMOUTH.

The Department of Psychiatry, in a unique collaboration with the State of New Hampshire, is seeking two faculty Child and Adolescent Psychiatrists. These psychiatrists will join a growing team of child psychiatrists that provide Child & Adolescent Psychiatric services at New Hampshire Hospital's Philbrook Center for youth and the Sununu Youth Services Center for juvenile justice.

These positions offer an academic opportunity as faculty members of the Geisel School of Medicine at Dartmouth. Teaching and supervision includes work with direct care staff, therapists, medical students, psychiatry residents, and child psychiatry fellows in advanced training from Dartmouth. Research opportunities abound in affiliation with the Dartmouth Trauma Interventions Research Center and ongoing projects at New Hampshire Hospital and Dartmouth-Hitchcock Medical Center.

Candidates should be board certified or board-eligible in Child & Adolescent Psychiatry. Academic rank and salary will be commensurate with experience. Curriculum vitae and three letters of reference addressed to Craig Donnelly, MD, Section Chief Child Psychiatry for the Department of Psychiatry, should be e-mailed to psychiatry.jobs@dartmouth.edu and reference Juvenile Justice in the subject line.

Dartmouth College is an Equal Opportunity/Affirmative Action employer strongly committed to achieving excellence through cultural diversity. The College actively encourages applications and nominations from women, minorities, veterans and persons with disabilities.

NEW JERSEY

CHILD & ADOLESCENT PSYCHIATRIST
Montclair, NJ

Child/Adolescent Psychiatrist for our Montclair, New Jersey location, to join our private fee-for-service comprehensive child, adolescent and adult therapy Center. Candidate will be part of a multi-disciplinary team and will provide psychiatric evaluation, medication management and, if desired, psychotherapy, in a supportive collegial atmosphere. He/She will also clinically oversee treatment at the Center. Salary and benefit package are generous, and include excellent medical and dental insurance benefits, generous vacation and CME time, retirement plan and more. Opportunities for growth also exist. Candidate must be board certified or board eligible in child/adolescent psychiatry. **E-mail cv to abbazn@aol.com.**

General Psychiatrist, Assistant Professor/Clinical Assistant Professor.UMDNJ-School of Osteopathic Medicine (SOM) Department of Psychiatry seeks two full time, board eligible or board certified MD or DO to provide services on an In-Patient psychiatric unit located in Southern New Jersey. We are an academic department with a mission dedicated to education, practice and research. There are opportunities for teaching residents and medical students. We offer a competitive salary and exceptional benefits to our faculty. If you are interested in joining our team, please forward your CV and cover letter to: Renee McNeece, Administrator, Department of Psychiatry at: mcneecrc@umdnj.edu. UMDNJ is an Equal Opportunity Employer.

NEW YORK CITY & AREA

MDs & NPs needed for Psychiatry **Consultation** services in Long Term Care Facilities (NH, SNF). **Locations:** Manhattan, Bronx, Brooklyn, Westchester (York Town Heights) & Staten Island, PT/FT Above average salaries/benefits, flexible hours. Please email CV to manager@medcarepc.com or via Fax: 718-239-0032 Tel:718-239-0030.

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.

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.

NEW YORK STATE

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

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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.

NORTH DAKOTA

Sanford Clinic North
Fargo, North Dakota
Seeking BC/BE Adult Psychiatrists

Medical Director, In-Patient and Partial Hospitalization Programs—Join a team of inpatient hospitalists covering a 24 bed inpatient unit and a partial hospitalization unit with a 16 bed capacity.

General Adult Psychiatrist—This position provides the opportunity to practice outpatient and in-patient psychiatry.

Sanford's Behavioral Health Sciences Department is staffed by more than 30 psychiatrists, clinical nurse specialists, doctorate-level psychologists and master's-level psychologists offering a continuum of care, from inpatient hospitalization and partial hospitalization programs, to outpatient individual and group therapy including eating disorders at the highly regarded Eating Disorders Institute. Responsibilities include teaching psychiatry resident and medical students through the University of North Dakota School of Medicine.

Sanford Health is the largest, rural, not-for-profit, health care system in the nation, serving 126 communities in seven states plus children's clinic services expanding into several countries.

Fargo, ND, a community of 190,000, offers excellent schools, a wonderful blend of cultural and recreational activities, low crime and affordable and upscale living.

Jean Keller, Physician Recruiter
Phone: (701) 280-4853
Email: Jean.Keller@sanfordhealth.org
www.sanfordhealth.org

OHIO

SOUTHERN OH – OUTPATIENT POSITION with some on-call duties for the geropsych unit. Salaried position with production & performance bonuses; medical school loan repayment plan up to $200k. Portsmouth is close to Ashland, KY, an hour from Huntington, WV; it is 80 miles from Columbus and 110 miles from Cincinnati. The hospital was named 10th in the Top 100 Best Places to Work by Modern Healthcare and 36th on Fortune's top 100 Best Companies to Work For. Join our top notch team at this beautiful, impressive hospital and enjoy working every day with a great group of people. H1/J1s welcome. Also need someone to help with some weekend coverage. Please **call Terry B. Good, Horizon Health, at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

OKLAHOMA

PSYCHIATRISTS
Join a Team that
Places the Patient First!

Humana Clinical Resources seeks full time BC/BE Psychiatrists for our military servicemen and women and their beneficiaries at Ft Sill, Lawton, OK. Outpatient, M-F 7:30AM – 4:30PM, No Call, No Weekends! Competitive compensation, Sign-on, Retention Bonus, Relocation Allowance, Malpractice, Paid Time Off and Federal Holidays. DEA, Active Unrestricted license in ANY of the 50 states, U.S. Citizenship. Recent experience preferred. Contact: Rina Katon at 1-866-949-8681, rkaton@humana.com, Fax: (502) 322-9751. www.humanaclinicalresources.com.

OREGON

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.

PENNSYLVANIA

ESCAPE THE TRAFFIC AND HASSELS OF LIVING IN A METRO AREA BUT HAVE AN EASY DRIVE TO SEVERAL– Lancaster is a lovely area and it is only about an hour to Philadelphia, 1 ½ hours to Baltimore, 2 hours to Washington DC and 3 hours to NYC. Inpatient position; adult and geriatric; attractive salary w/benefits plus bonus, or independent contractor arrangement if desired. Plans under way to open outpatient and other services. Grow with this program; join a great team and enjoy a great quality of life! Please **call Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

CLASSIFIEDS

PHILADELPHIA: General Psychiatrist - Inpatient Services. Call only 5x per year! Child Psychiatrist—Day Treatment. **CLARION:** Child Psychiatrist—Inpatient/Partial Services. **STATE COLLEGE:** General or Child Psychiatrists–Inpatient, Partial or all O/P programs. All positions offer salary, benefits, bonus opportunity. Contact Tiffany Crawford, In-house recruiter @ 866-227-5415 OR Tiffany.Crawford@uhsinc.com.

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.

RHODE ISLAND

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

We are recruiting for a number of full-time clinical positions which are part of an academic medical center program, with opportunities for Brown University Clinical Faculty appointments. There are possibilities for research participation for applicants with the appropriate background.

Outpatient Psychiatrist(s)to work with general psychiatry populations and to interface with primary care.

Inpatient Psychiatrist(s)to join our multidisciplinary treatment team providing care for 46 inpatients beds located in a general medical teaching hospital.

Emergency Psychiatrist(s): As the largest emergency psychiatry facility in the region, we are seeking to augment psychiatrist staffing with scheduled weekend coverage that includes some inpatient psychiatry coverage. The position(s) will be part of a team which includes psychiatry residents, nurses, and social workers.

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

SOUTH CAROLINA

Make A Difference in This Community/Hospital – Head up an 8-bed inpatient Geropsychiatric Unit; salaried with benefits or practice opportunity for those who prefer independent contract. Weekend call is one in four. Rounding on weekends is not necessary unless there is an admission on Friday or Saturday which is rare. Fantastic group of people to work with; huge amount of support. Located in northeast SC, easy drive to Florence, SC and Fayetteville, NC; 2 hours from Columbia, Myrtle Beach, Charlotte, Raleigh, and Wilmington. Please **call Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

Horizon Health seeks a **Psychiatrist** for part-time, weekend coverage for a 15-bed Geriatric Inpatient Psychiatric Program in **Spartanburg, SC.** 1 or 2 weekends per month. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com. EOE.

COLUMBIA – MYRTLE BEACH - AIKEN – GREENVILLE: General, Geriatric and Child Psychiatrists. Fulltime positions offering very competitive salary, benefits & bonus opportunity. Student loan assistance negotiable. Inpatient & Partial program services. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

TENNESSEE

SCHOOL OF MEDICINE
VANDERBILT UNIVERSITY

INPATIENT PSYCHIATRIST
Vanderbilt University School of Medicine, Department of Psychiatry

The Department of Psychiatry is recruiting psychiatrists to provide inpatient services at the Vanderbilt Psychiatric Hospital located on the campus of Vanderbilt University Medical Center. The hospital offers specialized inpatient programs for children & adolescents and for adults with mood, psychotic, and substance abuse disorders. Successful BE/BC candidates will receive a faculty appointment with rank and salary commensurate to experience.

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

Link to Annual Meeting Microsite:
http://annualmeeting.psychiatry.org/

Horizon Health, in partnership with **Livingston Regional Hospital** in **Livingston, TN**, near beautiful **Dale Hollow Lake,** has an exciting opportunity for a **Medical Director** at our 10-bed Geriatric Inpatient Psychiatric Program. Excellent income with great quality of life! 2 hours from Nashville and Knoxville and one of the lowest costs of living in the U.S. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com. EOE

TEXAS

PSYCHIATRIST
Utilize any current state license!

Humana Clinical Resources seeks a Full Time BC/BE Psychiatrist for our military servicemen. Outpatient only at Ft. Hood, TX. Mon-Fri., 7:30AM – 4:30PM. Limited beeper call. Sign-on, Retention Bonus, Relocation Allowance, Malpractice. Paid Time Off and Federal Holidays. DEA, Active Unrestricted license in **ANY** of the 50 states, U.S. Citizenship plus 2 years of recent experience or in training. Contact: Michelle Sechen 877-202-9069, msechen@humana.com, Fax: (502) 322-8759.

www.humanaclinicalresources.com.

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. Seeking C/A Psychiatrist to work on a children's unit and adolescent unit (new pavilion) in a very impressive general hospital that offers a full continuum of psychiatric care. This is an inpatient and outpatient position; salaried with benefits and attractive bonus plan. Top-notch staff; great quality of life—truly a "must see" position when considering a new job in a new place. Contact Terry B. Good at 1-804-684-5661, Fax #: 804-684-5663; terry.good@horizonhealth.com. EOE

Excellent private practice opportunity for a adult/ or child-trained psychiatrist in Southern West Virginia to join a well-established practice. In-patient, out-patient, and consultation services. Exceptional salary and benefits. Good place to raise children. Easy drive to several big cities, heaven for outdoor lovers. Can help with visa conversion and sponsorship. Fax cv to (304) 252-1703 or email nafa2 @aol.com.

Fellowships

UMASS
Addiction Psychiatry Fellowship

The UMass Addiction Fellowship in collaboration with the Bedford Veterans Center for Addiction Treatment (VCAT) has positions available for fellows to start on July 1, 2013. This fellowship program has affiliations with different private, public and federal sectors such as Adcare Hospital, Spectrum Health Systems, Community Healthlink and Bedford VA Hospital, that not only offers the fellow exposure to patients with a broad range of substance use disorders, but also prepares the fellow to be competent to succeed in highly demanding settings. Interested candidates should contact: Gerardo Gonzalez, MD, Director of Addiction Psychiatry Fellowship Program, Department of Psychiatry, University of Massachusetts Medical School, 365 Plantation Street, Worcester, MA 01605 or email gerardo.gonzalez@umassmed.edu. AA/EOE

OREGON HEALTH & SCIENCE UNIVERSITY/PORTLAND VA MEDICAL CENTER

OHSU/PVAMC in Portland, Oregon is recruiting Addiction Psychiatry, Geriatric Psychiatry, and Psychosomatic Medicine Fellows for the academic year beginning July 1, 2012. Fellowships are ACGME-accredited at the PGY5 level. These are OHSU fellowships based primarily at the PVAMC, with teaching provided by OHSU faculty. Portland is a beautiful and livable city with easy access to many outdoor recreational activities. Detailed information for fellowships may be found on-line at http://www.ohsu.edu/psychiatrytraining.

Addiction Psychiatry Fellowship. OHSU offers 2 Addiction Psychiatry fellowship positions. The fellowship is based at the Portland VA and includes rotations in the Opioid treatment and Buprenorphine programs, general substance abuse treatment programs [including co-occurring disorders], smoking cessation, pain/addiction, consult/liaison, and child/adolescent. OHSU is the site of the Methamphetamine Research Center, and the One Sky Center for Native American Addiction and Mental Health. A 2nd year devoted to research in the addictions is possible for selected candidates. Contact Marian Fireman MD, V3-SATP, P.O. Box 1035, Portland, OR 97207; Marian.Fireman@va.gov.

Geriatric Psychiatry Fellowship. OHSU offers two geriatric psychiatry fellowship positions. Training sites include both VA and OHSU geriatric psychiatry outpatient clinics; a private, dedicated geropsychiatry inpatient unit; a dementia clinic and geriatric medicine clinic; consultation to inpatient med/surg unit and a long-term care unit. Research strengths in health services research, dementia, ethics and end of life care. Contact Linda Ganzini MD, MPH at Portland VA Med. Ctr., R and D 66, P.O. Box 1034, Portland, OR 97207; Linda.Ganzini@va.gov.

Psychosomatic Medicine Fellowship. Flexible program with clinical, research, and teaching opportunities. Training sites include consultation to med/surg, ambulatory care, and specialty services. Research and clinical strengths are health services, mental disorders in primary care, pain, end-of-life/palliative care, ethics, Parkinson's disease, and substance abuse. Contact Todd Eisenberg MD, Portland VA Med. Ctr., P.O. Box 1034 (P3MHDC), Portland, OR 97207; Todd.Eisenberg2@va.gov.