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Newspaper of the
American
Psychiatric
Association

PSYCHIATRIC NEWS

inside

PERIODICALS:
TIME-SENSITIVE MATERIALS

Psychiatrists' Advocacy Can Help Change System in Crisis

APA's president says the fragility of the nation's mental health system is manifest in recent crises, including Katrina's devastation and the overwhelming number of returning veterans in need of mental health care.

BY MARK MORAN

From the flood-ravaged Gulf states to the flood of service members in need of mental health services after returning from Afghanistan and Iraq, America's fractured mental health system is up against profound challenges.

Speaking at APA's Institute on Psychiatric Services in still-devastated but slowly recovering New Orleans, APA President Carolyn Robinowitz, M.D., pointed out that the crises of the past several years have brought out the best and the worst in the nation's mental health care system.

She noted that the institute's location was an auspicious one for its theme this year of "Recovery: Patients, Families, Communities."

"Our location this year, determined long before Katrina, but all the more important now, provides a special venue in which to discuss primary and secondary interventions, resilience, and recovery for the community as well as individuals and their families," Robinowitz said. "Other external circumstances, such as the wars in Iraq and Afghanistan, have produced similar special needs in providing care for returning wounded and their families. Both have highlighted our many successes in providing care and promoting recovery as well as the major problems that beset our health care system.

"Both the military and Department of Veterans Affairs are overwhelmed by the number of service men and women with depression, traumatic brain injury, and PTSD and must deal not only with limited resources but with a culture that discourages seeking mental health care as well as with issues of continuity."

She emphasized that "reservists and National Guard members, particularly those from rural areas, may not have access to appropriate treatment, especially for later-appearing symptoms of PTSD, or may not be able to access appropriate care. Further, systems may deal only with the 'indicated patient' and not address the impact of multiple deployments on service families."

But she said there is a silver lining in the crisis facing returning veterans. "The

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APA President Carolyn Robinowitz, M.D., rings the ceremonial bell to signal the opening of APA's 2007 Institute on Psychiatric Services held last month in New Orleans. See articles at left and on pages 4, 6, 10, 14, and 18.

Credit: Ellen Dallager

Study Questions 'Real World' Benefits of Newer Antipsychotics

The second-generation antipsychotics may not change the compromised neurobiology that underlies cognitive deficits.

BY MARK MORAN

Are the cognitive benefits claimed by manufacturers of second-generation antipsychotics an artificial result of repetitive practice in test conditions?

That's what a randomized trial of risperidone and olanzapine comparing cognitive improvements among first-episode schizophrenia patients and healthy controls suggests. Risperidone is marketed by Janssen Pharmaceutica as Risperdal, and olanzapine is marketed by Eli Lilly and Co. as Zyprexa.

The study, reported in the October *Archives of General Psychiatry*, found that the cognitive improvements among patients were consistent in magnitude with the "practice effects"—the effects of exposure, familiarity, and procedural learning that naturally occur in test conditions—seen in healthy patients.

"It may be that these drugs are not improving cognition as much as previously thought," said study author Terry Goldberg, Ph.D. "Clinicians can't assume that patients are totally normalized in the cognitive domain, and in terms of research it suggests that trials of cognitive-enhancing drugs might include a comparison against healthy controls."

Goldberg is director of research in neurocognition, psychiatry at Zucker Hillside Hospital/Feinstein Institute in Glen Oaks, N.Y., and a professor of psychiatry at Albert Einstein College of Medicine.

In the study, 104 first-episode schizophrenia patients were randomized to treatment with olanzapine or risperidone. Sixteen cognitive tests were administered at baseline, six weeks, and 16 weeks, and

please see ***Antipsychotics*** *on page 24*

APA ELECTION 2008

Who Will Be APA's Next Leaders?

It's up to you to determine the answer to that question, and the December 1 issue of *Psychiatric News* will help you decide. That issue will contain information on the candidates running in APA's 2008 election. Ballots will be mailed to all voting members on December 22, and instructions for online voting will be e-mailed to all members for whom APA has an e-mail address on file. All ballots must be **received** by **February 5.**

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Depression Education Must Address Needs of Black Women

Depression can be treated successfully, yet many people in African-American communities are not benefiting from proper treatment due to stigma and poor access to culturally competent mental health care.

BY EVE BENDER

Intensifying depression outreach and education initiatives will fill a critical gap in African-American communities and help combat the stigma that keeps so many from receiving needed treatment.

This was the message delivered by panelists of the Depression is Real coalition. The coalition, of which the American Psychiatric Foundation is a member, is an advocacy group of medical and civic professionals dedicated to combating the stigma of mental illness and promoting the effectiveness of treatment. The seminar, titled "Black Women Surviving Unmet Mental Health Needs," was organized by the coalition and the Congressional Black Caucus Foundation in conjunction with Rep. Julia Carson (D-Ind.), a mental health advocate who has a family member with serious mental illness.

Panelists discussed the implications of unmet mental health needs among black women in September in Washington, D.C., and agreed that more must be done to reverse the trend of underrecognition and undertreatment of depression in that population.

"Minorities experience mental illness at disproportionate rates," noted American Psychiatric Foundation President Altha Stewart, M.D. "They are disproportionately lacking in access to mental health treatment," and when they do receive treatment, it is more likely to be inadequate compared with treatment received by nonminorities, she said.

She also pointed out that African Americans have increased rates of certain diseases that often go hand in hand with depression, such as hypertention, cardiovascular diseases, and certain types of cancer.

"There is also a risk of increased depression in African-American women related to psychosocial, economic, and environmental stressors," Stewart noted.

Blending depression screening and education with other health initiatives in minority populations—maternal and child health, infant mortality, or HIV/AIDS prevention for instance—is one way to improve rates of successful depression treatment, she said.

In addition, it is crucial that mental health professionals and treatment advocates partner with traditionally black social organizations so that they can be sure that their messages are heard. Such organizations may include the National Urban League, the National Association for the Advancement of Colored People, and local churches. "We don't do enough to promote an image of hope and recovery for black women with depression," she said.

One reason African Americans may receive substandard treatment is that mental health care providers of other races may not be trained in the cultural issues impacting the lives of African Americans and because there is a shortage of African-American psychiatrists and psychologists in the United States.

Stewart and Rahn Bailey, M.D., chair of the National Medical Association's Sec-

please see ***Depression*** *on page 11*

Credit: John Harrington

Psychiatrist Rahn Bailey, M.D., says at an event cosponsored by the Congressional Black Caucus Foundation on depression in black women that due to a shortage of African-American psychiatrists and mental health professionals, it is essential that those providing treatment to black patients are trained in the cultural issues that impact their lives.

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- ***Psychiatric News* Web Site:** pn.psychiatryonline.org/
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New Orleans Ideal Location For APA's Community Meeting

BY CAROLYN ROBINOWITZ, M.D.


©Sylvia Johnson Photography 2007

APA's 59th Institute on Psychiatric Services took place last month in New Orleans. The institute, which occurs each autumn, is our smaller meeting with a focus on clinical care, especially for the most vulnerable patient populations.

Its theme, "Recovery: Patients, Families, and Communities," addressed the institute's mission: "to train and support psychiatrists to provide quality care and leadership through study of the array of clinical innovations and services necessary to meet the needs of individuals who suffer from serious mental illness, substance abuse, or other assaults to their mental health due to trauma or adverse social circumstances, in order to assure optimal care and hope of recovery."

Under the superb leadership of Steve Goldfinger, M.D., who chaired the Scientific Program Committee, and with marvelous collaboration from the American Association of Community Psychiatrists, the institute focused on the translation of science to clinical care, addressing themes such as best care practices, collaboration with other health and mental health professionals, relations with patient and family advocacy groups, the criminal justice system, cultural sensitivity, homelessness, public mental health planning, education, care for members of the military, health services research, and the meaning of and goals for recovery. Obviously, the meeting's location emphasized issues regarding disaster response and included participation in community-support activities. (Look throughout this issue of *Psychiatric News* and the next for articles on this year's sessions and events.)

A conference within a conference was held by APA's Office of Minority and National Affairs (OMNA), furthering its work in eliminating mental health disparities in diverse and underserved populations. "OMNA on Tour in the Gulf Coast" featured multiple formats addressing cultural diversity; co-occurring disorders; regional issues; resilience in special populations, including children, youth, elderly, and the GLBT community; wellness strategies for recovery personnel; and mental health–faith community collaborative approaches through the All Healers Mental Health Alliance.

While we were glad to see that recovery efforts are progressing in New Orleans—albeit slowly—we noted that major structural and systemic problems affecting mental health services remain. During our stay, I participated in the Doctors Back to School (DBTS) program sponsored by OMNA and the AMA. Aimed at elementary, middle school, and high school students in minority and underserved communities, DBTS is designed through modeling and information to encourage young people to consider careers in medicine. We visited the Benjamin Franklin Charter High School and met with administrators, teachers, and students, learning about their post-Katrina experiences, as well as providing encouragement and education about medical careers in general and psychiatry in particular.

Earlier in my career, I worked primarily in the public sector and found that the institute's focus on community psychiatry addressed many of my educational needs and did so in an interactive environment. While this focus remains, the institute has become a very popular learning environment for residents, early career psychiatrists, and medical students—the last through PSYCHsign, an organization for medical students with an interest in psychiatry. Many sessions focused on this population, including a "Meet the Experts" luncheon meeting, during which attendees sat at tables with psychiatric leaders and learned about specialty areas and practice topics such as academic psychiatry, forensic psychiatry, leadership, psychodynamic psychotherapy, and research and networking with peers as well as APA leaders. Also enfolded in the institute program was a two-day leadership conference for chief residents and programs for APA resident fellows.

On Saturday evening, the American Psychiatric Foundation presented "Conversations at the Institute on Psychiatric Services: A Night for New Orleans," bringing together mental health organizations central to the recovery of the New Orleans community. The reception included music and entertainment, refreshments, and a silent auction. We heard stories of survival and recovery after Katrina by wonderful musicians (see page 4). Proceeds benefited these organizations as well as efforts to advance public mental health education.

The meeting was not all work and study. New Orleans also provided relaxation and leisure activities, as well as its legendary fine food. During a break, I walked through the French Quarter and an arts area, appreciating architecture, art displays, and shops. The quarter is essentially undamaged, and with the return of citizens as well as convention goers and tourists, economic recovery is well under way. The convention and hotel industry is working to ensure that visitors enjoy their stay, and we were constantly greeted with appreciation for being there as well as with excellent service.

We will return to the Big Easy in May 2010 for our annual meeting. ■

State Hospitals Struggle To Give Up Smoking

Persons with mental illness are often heavy smokers, but efforts are under way to implement no-smoking policies in public psychiatric facilities.

BY AARON LEVIN

"Smoking kills, and it kills seriously mentally ill people early," Mary Diamond, D.O., said at the APA Institute on Psychiatric Services in New Orleans in October.

About 75 percent of seriously mentally ill people are tobacco dependent—over three times the rate among the general population—yet 59 percent of public mental health facilities still permit smoking, she said. Even some states that have banned cigarettes in prisons continue to allow smoking in their mental hospitals.

"The goal of mental health systems is recovery, and smoking doesn't promote recovery," said Diamond, chief psychiatric officer in Pennsylvania's Office of Mental Health and Substance Abuse.

Historically, smoking has been viewed as a form of self-medication or at least a minor comfort for patients in psychiatric hospitals. Cigarettes were even manufactured at some hospitals and are sold at some today.

"Revenue from sales of tobacco provides discretionary income for facilities," wrote Joseph Parks, M.D., and Peggy Jewell, M.D., last year in a report for the National Association of State Mental Health Program Directors (NASMHPD). Parks and Jewell also spoke at the institute. "Smoke breaks for staff and patients have become an 'entitlement,' deserved, and protected, and one of the only times [patients] can practice relating to each other and staff in a 'normalized' way."

Smoking's effects go beyond addiction and the well-known damage to the body, Parks noted. Cigarettes are used by staff as a tool for coercion or reward, he said. Their presence leads not to more docile patients but rather to deleterious outcomes. Cigarettes form the basis of a black-market economy and become a precursor to threats between patients. Anxiety rises as many patients remain in a state of withdrawal awaiting the special break times when they can go outside and smoke. That leads, in turn, to an increase in use of seclusion and restraint when they grow agitated. Smoking also eats up about 15 percent of staff time, when staff members accompany patients out of doors, Parks said.

Ban Means More Treatment Time

"Making state facilities smoke free means a healthier environment, less violence, more time for treatment, and less time for smoking—and fewer wastebasket fires," said Parks, medical director of the Missouri Department of Mental Health.

Changing a facility to smoke-free status is not a simple matter, however. Incremental approaches seem unsatisfactory, he said. Smoking-cessation programs are rarely offered, and even when they are, few patients attend them.

Directives from above can founder, as well. For example, an initial attempt at institutional smoking cessation in Minnesota failed when the state's top mental health leadership did not discuss the process with middle managers and unit managers.

"Staff are the biggest source of resistance," said Parks. They resent the loss of their own smoking privileges and the increased need for policing contraband. Arguments about "freedom of choice," however, ring hollow because "addiction is not a choice," he emphasized.

Extensive Planning Time Needed

At least a year's worth of planning will be needed to overcome that resistance, said Jewell, who is medical director of Oklahoma's Department of Mental Health and Substance Abuse Services. Preparation should begin with discussions of the harmful health effects of smoking and the benefits of quitting.

Social and peer support is crucial, and ex-smokers have a lot of credibility in that area, added Diamond. Institutions can enrich programs to take up the time once devoted to smoke breaks. "Fresh-air breaks" can give patients and staff time off the unit without the hazards of smoking.

Nine months before the changeover in Oklahoma, all employees were offered a 90-day, nicotine-replacement program and other help to quit smoking. The department had a one-time cost of $25,000 for 3,775 employees, inducing about 15 percent of the employees to quit after this initial effort.

The department also spent $100,000 for nicotine-replacement patches for 8,864 patients, plus $2,500 for signs and posters about the policy change.

Quitting can even maintain the bond previously formed when staff and patients smoked together if a staff member says, "I'm using the patch to quit and so can you."

Benefits from a changeover to nonsmoking include reduced sick call for patients and less violence or disruptive behavior. However, Diamond noted, costs in Oklahoma rose to repair disabled smoke detectors, toilets stopped up by contraband cigarettes, and electrical outlets taken apart to serve as lighters.

In Texas, both employees and patients at Wichita Falls State Hospital were unhappy at the prospect of change. The employees complained to the news media about the proposed ban, but the administration had already contacted the press about the change, which defused employees' complaints.

Patients' rights groups also opposed the ban but were outflanked when an initially sympathetic legislature banned smoking in all public places. Despite this initial resistance, there was no change in employee recruitment or retention patterns after the change. In fact, a smoke-free workplace is now considered a benefit to working at the hospital, and human-resources staff emphasize the no-smoking policy up front to make it clear to potential hires.

Although the policy applies equally to patients and staff, patient violations should be viewed as treatment issues, but staff violations become personnel matters, said Jewell.

A NASMHPD toolkit for hospitals transitioning to a no-smoking policy is posted at <www.nasmhpd.org/general_files/publications/NASMHPD.toolkitfinal updated90707.pdf>. ■

Local Musicians Jazz Up New Orleans Institute

By combining stories of hardship and survival with the music that made the city famous, New Orleans jazz musicians share a bit of their lives and talents with IPS attendees.

BY EVE BENDER

As the notes of the clarinet and other brass instruments in the Original Liberty Jazz Band soared to new heights, hope became palpable at the Institute on Psychiatric Services (IPS) last month in New Orleans.

It was the end of a busy day of sessions at the IPS, and Michael White, Ph.D., professor, music historian, and jazz musician was playing his heart out with members of his band at the Conversations event, sponsored by the American Psychiatric Foundation.

The event—which also featured Zydeco musician Amanda Shaw and her band, the Cute Guys, and Charmaine Neville—had funding from AstraZeneca, Wyeth Pharmaceuticals, Forest Pharmaceuticals, and Janssen.

"Playing music has been therapeutic for me," said White, who spoke about surviving Hurricane Katrina. White teaches African-American music and holds a teaching chair in the Department of Humanities at Xavier University in New Orleans.

He pointed out that less than two-thirds of New Orleans residents have returned since mass evacuations from Hurricane Katrina, and for those who have, "life has been one, long continuous struggle."

Suicide rates and stress-related deaths have been on the rise in New Orleans since Katrina, he said.

Credit: Lindsey McClenathan

Michael White, Ph.D., poses with American Psychiatric Foundation President Altha Stewart, M.D. He told institute attendees that even after losing most of his prized possessions to the wrath of Hurricane Katrina, he felt lucky to be able to continue playing music.

He observed that it is not uncommon for obituary listings in the *Times Picayune* to require three to four pages of space when pre-Katrina listings were usually only two pages.

White's home, located in the Gentilly neighborhood of New Orleans, was flooded with eight feet of water for nearly three weeks. "The contents of the house included my life's work," he said. All was lost, including an archive of 4,000 books, more than 6,000 recordings, 50 vintage clarinets, musical memorabilia, thousands of photographs, and rare interviews with jazz musicians born in the late 1800s and early 1900s.

"I'd also become a composer in the last few years and had written 24 new songs, only 10 of which I'd recorded," White said. The remainder was lost to the floodwaters.

White also found resettling in Houston to be a difficult and painstaking process.

He relocated with his mother and aunt, who were both in their 80s. After moving, their mental and physical health began to deteriorate rapidly "due to the devastation caused by Katrina and their displacement."

White noted that "many people like my mother and aunt had been away from New Orleans longer than they had ever been before in their lives and didn't know what would happen with their homes, or if they would ever be able to return, and those problems were really devastating for them."

While White's relatives are back in Louisiana now, the future is still uncertain for White and thousands of others. "When Katrina brought all that devastation, for me, it was the end of life as I knew it," he said. "But I came to realize that I'm very fortunate because the most valuable things I have not lost."

He has the memories and rich tradition of New Orleans jazz, he said, and the ability to play music and perform for audiences. "That's what I like to do most," he said. ■

Drug's Availability Doesn't Mean FDA Has Approved It

Not all drugs on the market have been approved by the FDA as safe and effective, and many unapproved drugs are prescribed by physicians unaware of their illegal status.

BY JUN YAN

There may be thousands of drug products being prescribed and dispensed to patients in the United States that have never been reviewed by the Food and Drug Administration (FDA) for safety and efficacy or approved for marketing. The agency is now taking steps to address the potentially large problem.

In June 2006, the FDA released a guidance document, "Marketed Unapproved Drugs—Compliance Policy Guide," to clarify the rules regarding drugs on the market that have not been reviewed or approved by the agency's normal process and the agency's plan to enforce them.

Many of these unapproved drugs are advertised and listed in reference books such as the *Physicians' Desk Reference*, prescribed by physicians, and dispensed or sold to patients, according to the FDA guidance document. Physicians and pharmacists are usually not aware of the unapproved status of these drugs, which can be distributed based on a 10-digit number known as the National Drug Code (NDC). The NDC number is issued to all types of drug products, including unapproved investigational drugs, and does not guarantee a drug's approval status. These products' labeling information does not distinguish their approval status, nor is the labeling necessarily reviewed by the FDA for safety claims and indications.

The FDA says on its Web site that most of these products remain on the market illegally for "a variety of historic reasons." Most became available before the Federal Food, Drug, and Cosmetic Act was revised in the 1960s to require that a new drug be evaluated by the FDA for efficacy as well as safety. Before these regulations, new drugs only needed to be shown as safe, and drugs deemed the same or similar to approved drugs needed no independent review and approval process by the agency. The labels of these products may not conform to current regulatory standards and may carry unapproved claims and indications. Although the FDA had contracted with the National Academy of Sciences/National Research Council to evaluate the effectiveness of thousands of products approved only for safety between 1938 and 1962, not all products have gone through the approval process.

Even the drug products deemed illegal have not all been forced off the market. Other provisions in the regulations have allowed older drugs without labeling updates to slip through the cracks.

It is unknown how many currently marketed drugs are unapproved, and the agency does not maintain a complete list of these products. The guidance estimated that "several thousand drug products are marketed illegally without required FDA approval" today and admits that the agency is "unable to take action immediately against all. . .illegally marketed products" because of a lack of resources.

Since the release of the guidance last year, the FDA has been systematically issuing sanctions against certain unapproved products by demanding their withdrawal from the market or convincing some manufacturers to go through the official process by filing a New Drug Application for the agency's review in order to legalize their products and update the product labeling. A short list of drugs and manufacturers against which enforcement actions have already been taken is posted on the FDA's Web site.

The guidance document claims that the enforcement priorities are given to drugs that have potential safety risks, lack evidence of effectiveness, are fraudulently promoted and sold, "present direct challenges to the new drug approval and [over-the-counter] drug monograph systems," or are reformulated to evade FDA enforcement action. Priority is also given to unapproved new drugs that violate the regulations in other ways.

In 2006, unapproved products containing quinine and carbinoxamine with unapproved labeling were targets. This September, the agency announced that it will take "enforcement action" against manufacturers of unapproved hydrocodone-containing cough syrups, citing reports of medication errors due to formulation changes in the unapproved products and confusion over their brand names. The agency is also concerned that "no hydrocodone cough suppressant has been established as safe and effective in children under 6 years of age, and some of these unapproved products carry labels with dosing instructions for children as young as 2 years old," warned Steven Galson, M.D., M.P.H., director of the FDA's Center for Drug Evaluation and Research in a press release.

The FDA Web page lists selected drugs and companies that have been cited for enforcement actions, but includes no psychiatric drugs. However, the FDA has not released a complete list of all unapproved drug products on the market. Psychiatrists may be treating patients who are taking, for example, unapproved hydrocodone, levothyroxine, and quinine products (for restless legs syndrome).

Additional information about unapproved drugs and FDA actions is posted at <www.fda.gov/cder/drug/unapproved_drugs/default.htm>. "Guidance for FDA Staff and Industry: Marketed Unapproved Drugs—Compliance Policy Guide" is posted at <www.fda.gov/cder/guidance/6911fnl.pdf>. ■

Lilly Agrees to Zyprexa Labeling On Glucose-Metabolism Risk

The official prescribing information for olanzapine acknowledges mounting evidence that not all atypical antipsychotics are equal when it comes to unwanted metabolic effects.

BY JUN YAN

After much negotiation with the Food and Drug Administration (FDA), Eli Lilly and Co. has recently updated the labeling information of its atypical antipsychotic drug olanzapine (Zyprexa) to highlight its effect on glucose metabolism.

The labeling for olanzapine had carried the class warnings for the risks of diabetes mellitus and weight gain as mandated by the FDA since 2003 (*Psychiatric News*, October 17, 2003).

Clinical reports have accumulated in recent years to suggest that olanzapine has a greater effect on weight gain and glucose metabolism than do other atypical antipsychotics. In the package insert for olanzapine, dated October 1, the warnings section has been expanded to include hyperglycemia, hyperlipidemia, and weight gain. Data in adults and adolescents are presented separately (olanzapine is not approved for use in patients under age 18). Notably, the warnings acknowledge that "the association between atypical antipsychotics and increases in glucose levels appears to fall on a continuum, and olanzapine appears to have a greater association than some other atypical antipsychotics." The warnings also contain wordings about "significant, sometimes very high (>500 mg/dL) elevations of triglyceride levels" and "modest mean increases in total cholesterol" associated with olanzapine use.

The drug-label changes reflect pooled adverse-event data in Lilly's clinical trials and reports in the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) and Comparison of Atypicals for First-Episode Psychosis (CAFE) studies, according to the company's press release on the labeling changes. Both studies involved long-term, head-to-head comparisons of atypical antipsychotic drugs. The CATIE study was funded by the National Institute of Mental Health, and the CAFE study was funded by AstraZeneca, the maker of quetiapine (Seroquel).

APA has commissioned a work group to review all available evidence concerning the metabolic risks of antipsychotic drugs. John Newcomer, M.D., who is a professor in the psychiatry, psychology, and medicine departments and medical director of the Center for Clinical Studies at Washington University School of Medicine in St. Louis and leads the APA effort, told *Psychiatric News* that the report resulting from the review will present a comprehensive overview of the background and available clinical evidence on this medical issue. The paper will also provide clinical recommendations for screening, monitoring, and reducing cardiovascular and metabolic risks in patients treated with antipsychotic medications. The draft is expected to be finalized soon.

The FDA's efforts that led to Lilly's olanzapine labeling change are an acknowledgement of the evidence, including high-quality data from the NIMH-funded CATIE study, that has consistently shown the differential risks of weight gain, altered triglyceride levels, and potential hyperglycemia across different antipsychotics, said Newcomer.

He strongly urged psychiatrists, primary care providers, and health care systems to screen and monitor schizophrenia patients more actively for weight, body mass index, lipid profiles, glucose levels, blood pressure, and key indicators of cardiometabolic risks.

"Unfortunately, psychiatrists cannot assume that an internist or primary care provider is taking care of [cardiovascular assessments and treatments], often because patients do not see any physician besides their psychiatrist. Psychiatrists should participate in the screening and monitoring of metabolic risk at the start of and during antipsychotic treatment and make appropriate referrals to primary or specialty care providers to address identified risk factors and, importantly, follow up on these referrals," he said.

Earlier this year Lilly announced billions of dollars in legal settlements with patients who filed suits alleging that they were harmed by the drug. The plaintiffs also alleged that Lilly withheld or downplayed information regarding significant adverse effects associated with olanzapine, though Lilly denies any such wrongdoing, according to reports in the January 5 *New York Times* and February 2 *Psychiatric News*.

The updated labeling information for olanzapine is posted at <pi.lilly.com/us/zyprexa-pi.pdf>. ■

Apply Now for Administrative Certification

The Certification in Psychiatric Administration and Management is offered yearly in conjunction with APA's annual meeting. The application deadline for certification candidates (including letters of reference) is January 31, 2008. Early applications are encouraged to allow candidates adequate preparation time.

More information is available from Crystal Garner at cgarner@psych.org or online at <www.psych.org/edu/cert-psych.cfm>. ■

Malingerers May Be Annoying, But Don't Write Them Off

A psychiatrist's own irritation with patients presenting with false symptoms in the emergency department may be the first step toward treatment.

BY AARON LEVIN

People who lie, threaten, or manipulate others to gain medical attention have few friends in the health care system. Malingerers are even less welcome in the psychiatric emergency room, where overstretched resources must be saved for those who need them most, Jon Berlin, M.D., said at the APA Institute on Psychiatric Services in New Orleans in October.

Nevertheless, malingerers should not be written off by hospital staff, and the very annoyance induced by their pleas for medical care may open doors to the real needs of this population, he said.

"We know more about detecting malingering than about therapeutic interventions," said Berlin, medical director of crisis services at Milwaukee County Behavioral Health Division and an assistant clinical professor of psychiatry at the Medical College of Wisconsin. The real question is what to do once a malingerer is found out.

He recalled one patient who said, "I want to be in the hospital." Berlin told him he *was* in the hospital, to which the patient replied, "But I want to be deeper in the hospital."

"This is as deep as you're going to get," Berlin said firmly.

Others mix psychopathology with symptom exaggeration to try to get the medical attention they want. Many people threaten suicide to gain admission or achieve some other end, said Berlin.

A different patient, feeling "overwhelmed," also asked to be hospitalized. When Berlin denied her request, she asked what would happen if she said that she was suicidal. Berlin said that approach would destroy the trust between patient and physician, and he referred her to a respite house to stabilize.

"These individuals make us feel manipulated and taken advantage of," he said. "That leads to feelings of dread on our part. We feel dehumanized by them, and so we dehumanize them back. We start to think of them only as 'that malingerer.' "

Credit: Ellen Dallager

Malingerers are the bane of psychiatric emergency departments, but that doesn't mean they're not sick, said Jon Berlin, M.D. (foreground), at APA's Institute on Psychiatric Services in New Orleans. "Why not try to be productive with them?" Other panelists (from left) included Scott Zeller, M.D., Rachel Glick, M.D., and Carla Edwards, M.D.

Faced with such patients, emergency physicians need to ferret out exaggeration, do thorough evaluations, practice good risk management—and stand firm, he emphasized. Many malingerers begin as outpatients and then end up making repeat visits to the emergency department. The department should consider them as established patients, not new intakes, and take progress notes that can help guide staff efforts the next time they appear.

Malingerers are people who have often burned their bridges with the people around them, said Berlin. Their only success in life comes from making others fail. By default, they become cases for psychiatrists. Yet they are rarely well people. Many have psychiatric or physical comorbidities, he said. "So why not try to be productive with them?"

Helping them can begin with the very feelings of anger or disgust that malingerers engender in physicians and other staff. That internal barometer can serve as an indicator of a patient's status for the psychiatrist, as an EKG does for a cardiologist.

"We have to be aware of these emotions and let them be cues for us and for others," he said.

He recounted another case in his hospital of a man in his 50s with diabetes, cardiovascular disease, a cocaine habit, and a mood disorder who was hostile and demanding while on the observation unit. He was placed in restraints after he threatened a pregnant chief resident and knocked over a table.

This was not the patient's first appearance at the hospital. When he was discharged after observation, Berlin overcame his distaste and walked out of the hospital with the man to explore further his potential for insight or change.

Why did he threaten the chief resident? he asked the man. What did he plan to do with the rest of his life?

"Probably a majority of these patients are not treatable, but engaging them can reinforce traits in ourselves that can be helpful with other patients who are more receptive," said Berlin.

However, emergency departments must also set limits on unacceptable behavior to protect staff, he said. "We shouldn't allow any mistreatment by either side."

The policy in his health system calls for pressing charges against patients who cross beyond temper tantrums to the realm of felonies, he said. Sometimes that is not the solution it may seem at first glance. Berlin has seen cases in which such patients are taken to jail, threaten suicide there, and are returned—often the same afternoon—to the psychiatric emergency room. ■

Psychiatrist Gives Practical Advice For Avoiding Violence by Patients

Advance preparation and careful use of language can often reduce the potential for violence in psychiatric emergency settings

BY AARON LEVIN

"A soft answer turneth away wrath; but a grievous word stirreth up anger," says the Book of Proverbs, not routinely considered a handbook for psychiatrists working in hectic emergency departments.

Yet potentially dangerous situations can often be defused with advance planning and use of tactics that verbally calm agitated patients before they revert to violence, advised Houston emergency room psychiatrist Avrim Fishkind, M.D., president of the American Association for Emergency Psychiatry. He spoke at a session on emergency-room psychiatry at APA's Institute on Psychiatric Services in New Orleans in October.

Credit: Ellen Dallager

Avrim Fishkind, M.D., president of the American Association for Emergency Psychiatry, advises psychiatrists to use the verbal to avoid the physical when dealing with agitated patients in the emergency department.

For a start, prepare the ground and yourself, said Fishkind, who is medical director of the NeuroPsychiatric Center of Houston at the Harris County Mental Health and Mental Retardation Authority. Remove your ties, earrings, or necklaces, and calmly clear the room of other patients and unneeded staff. Secure the perimeter but keep security personnel outside the room. Resist any temptation to shout at or grab the patient. Maintain a calm demeanor with hands open, arms uncrossed, and turn your body partially sideways to protect vital organs in case of assault.

Keep at least a double arm's length away from the patient, both to respect the patient's personal space and to avoid injury. Maintain normal eye contact (neither staring nor looking away), and offer a visual line of egress by not standing between the patient and the door. Move farther back if the patient requests it.

"If you're worried about who is closest to the door, you shouldn't be in the room," chimed in fellow panelist Jon Berlin, M.D. "Fake [receiving] a page and get out."

Address the patient by name and identify yourself and your position as a physician, Fishkind continued. Don't lecture. Speak in short, clear phrases or sentences. To reinforce what you're saying and avoid confusion, repeat the same phrase and ask questions frequently to check patients' understanding. Listen and nod in agreement often.

Try to identify what the patients want and make clear your own wants and needs in this emergency situation. Are they sad, fearful, or angry? Suggest a behavior change that works for both sides: "If you will . . . then we will. . ." Offer alternatives, but also lay down the law, too, to establish your limits. Make it clear where you must agree to disagree. Offer quiet time, if the patient needs it, so he or she can contemplate the next step.

Later, debrief the patient both as a matter of respect and as a means of learning how to deal with future crises.

An article by Fishkind, "Calming Agitation With Words, Not Drugs," can be accessed at <www.currentpsychiatry.com/article_pages.asp?AID=494&UID=63272> after registering on the site. ■

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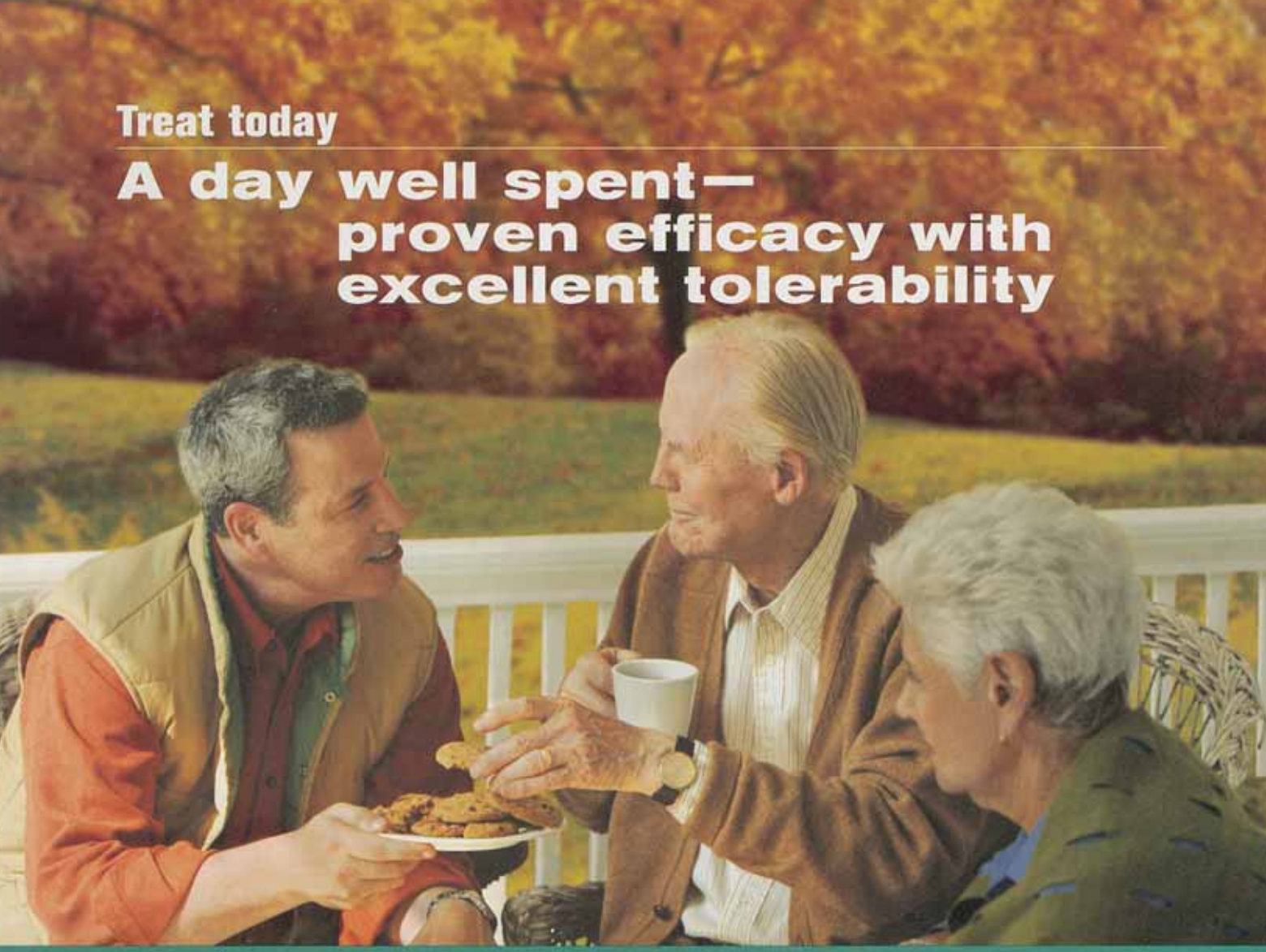

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References: 1. Reisberg B, Doody R, Stöffler A, Schmitt F, Ferris S, Möbius HJ, for the Memantine Study Group. Memantine in moderate-to-severe Alzheimer's disease. *N Engl J Med.* 2003;348:1333-1341. **2.** Tariot PN, Farlow MR, Grossberg GT, Graham SM, McDonald S, Gergel I, for the Memantine Study Group. Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. *JAMA.* 2004;291:317-324. **3.** Cummings JL, Schneider E, Tariot PN, Graham SM, for the Memantine MEM-MD-02 Study Group. Behavioral effects of memantine in Alzheimer disease patients receiving donepezil treatment. *Neurology.* 2006;67:57-63. **4.** Data on file. Forest Laboratories, Inc. **5.** NAMENDA® (memantine HCl) Prescribing Information. Forest Pharmaceuticals, Inc., St Louis, Mo. **6.** Winblad B, Poritis N. Memantine in severe dementia: results of the 'M-BEST Study (Benefit and efficacy in severely demented patients during treatment with memantine). *Int J Geriatr Psychiatry.* 1999;14:135-146.

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INDICATIONS AND USAGE
Namenda (memantine hydrochloride) is indicated for the treatment of moderate to severe dementia of the Alzheimer's type.

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PRECAUTIONS
Information for Patients and Caregivers: Caregivers should be instructed in the recommended administration (twice per day for doses above 5 mg) and dose escalation (minimum interval of one week between dose increases).

Neurological Conditions
Seizures: Namenda has not been systematically evaluated in patients with a seizure disorder. In clinical trials of Namenda, seizures occurred in 0.2% of patients treated with Namenda and 0.5% of patients treated with placebo.

Genitourinary Conditions
Conditions that raise urine pH may decrease the urinary elimination of memantine resulting in increased plasma levels of memantine.

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Namenda undergoes partial hepatic metabolism, with about 48% of administered dose excreted in urine as unchanged drug or as the sum of parent drug and the N-glucuronide conjugate (74%). The pharmacokinetics of memantine in patients with hepatic impairment have not been investigated, but would be expected to be only modestly affected.

Renal Impairment
No dosage adjustment is needed in patients with mild or moderate renal impairment. A dosage reduction is recommended in patients with severe renal impairment.

Drug-Drug Interactions
N-methyl-D-aspartate (NMDA) antagonists: The combined use of Namenda with other NMDA antagonists (amantadine, ketamine, and dextromethorphan) has not been systematically evaluated and such use should be approached with caution.

Effects of Namenda *on substrates of microsomal enzymes: In vitro* studies conducted with marker substrates of CYP450 enzymes (CYP1A2, -2A6, -2C9, -2D6, -2E1, -3A4) showed minimal inhibition of these enzymes by memantine. In addition, *in vitro* studies indicate that at concentrations exceeding those associated with efficacy, memantine does not induce the cytochrome P450 isoenzymes CYP1A2, CYP2C9, CYP2E1, and CYP3A4/5. No pharmacokinetic interactions with drugs metabolized by these enzymes are expected.

Effects of inhibitors and/or substrates of microsomal enzymes on Namenda: Memantine is predominantly renally eliminated, and drugs that are substrates and/or inhibitors of the CYP450 system are not expected to alter the metabolism of memantine.

Acetylcholinesterase (AChE) inhibitors: Coadministration of Namenda with the AChE inhibitor donepezil HCl did not affect the pharmacokinetics of either compound. In a 24-week controlled clinical study in patients with moderate to severe Alzheimer's disease, the adverse event profile observed with a combination of memantine and donepezil was similar to that of donepezil alone.

Drugs eliminated via renal mechanisms: Because memantine is eliminated in part by tubular secretion, coadministration of drugs that use the same renal cationic system, including hydrochlorothiazide (HCTZ), triamterene (TA), metformin, cimetidine, ranitidine, quinidine, and nicotine, could potentially result in altered plasma levels of both agents. However, coadministration of Namenda and HCTZ/TA did not affect the bioavailability of either memantine or TA, and the bioavailability of HCTZ decreased by 20%. In addition, coadministration of memantine with the antihyperglycemic drug Glucovance® (glyburide and metformin HCl) did not affect the pharmacokinetics of memantine, metformin and glyburide. Furthermore, memantine did not modify the serum glucose lowering effect of Glucovance®.

Drugs that make the urine alkaline: The clearance of memantine was reduced by about 80% under alkaline urine conditions at pH 8. Therefore, alterations of urine pH towards the alkaline condition may lead to an accumulation of the drug with a possible increase in adverse effects. Urine pH is altered by diet, drugs (e.g. carbonic anhydrase inhibitors, sodium bicarbonate) and clinical state of the patient (e.g. renal tubular acidosis or severe infections of the urinary tract). Hence, memantine should be used with caution under these conditions.

Carcinogenesis, Mutagenesis and Impairment of Fertility
There was no evidence of carcinogenicity in a 113-week oral study in mice at doses up to 40 mg/kg/day (10 times the maximum recommended human dose [MRHD] on a mg/m² basis). There was also no evidence of carcinogenicity in rats orally dosed at up to 40 mg/kg/day for 71 weeks followed by 20 mg/kg/day (20 and 10 times the MRHD on a mg/m² basis, respectively) through 128 weeks.

Memantine produced no evidence of genotoxic potential when evaluated in the *in vitro S. typhimurium* or *E. coli* reverse mutation assay, an *in vitro* chromosomal aberration test in human lymphocytes, an *in vivo* cytogenetics assay for chromosome damage in rats, and the *in vivo* mouse micronucleus assay. The results were equivocal in an *in vitro* gene mutation assay using Chinese hamster V79 cells.

No impairment of fertility or reproductive performance was seen in rats administered up to 18 mg/kg/day (9 times the MRHD on a mg/m² basis) orally from 14 days prior to mating through gestation and lactation in females, or for 60 days prior to mating in males.

Pregnancy
Pregnancy Category B: Memantine given orally to pregnant rats and pregnant rabbits during the period of organogenesis was not teratogenic up to the highest doses tested (18 mg/kg/day in rats and 30 mg/kg/day in rabbits, which are 9 and 30 times, respectively, the maximum recommended human dose [MRHD] on a mg/m² basis).

Slight maternal toxicity, decreased pup weights and an increased incidence of non-ossified cervical vertebrae were seen at an oral dose of 18 mg/kg/day in a study in which rats were given oral memantine beginning pre-mating and continuing through the postpartum period. Slight maternal toxicity and decreased pup weights were also seen at this dose in a study in which rats were treated from day 15 of gestation through the post-partum period. The no-effect dose for these effects was 6 mg/kg, which is 3 times the MRHD on a mg/m² basis.

There are no adequate and well-controlled studies of memantine in pregnant women. Memantine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers
It is not known whether memantine is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when memantine is administered to a nursing mother.

Pediatric Use
There are no adequate and well-controlled trials documenting the safety and efficacy of memantine in any illness occurring in children.

ADVERSE REACTIONS
The experience described in this section derives from studies in patients with Alzheimer's disease and vascular dementia.

Adverse Events Leading to Discontinuation: In placebo-controlled trials in which dementia patients received doses of Namenda up to 20 mg/day, the likelihood of discontinuation because of an adverse event was the same in the Namenda group as in the placebo group. No individual adverse event was associated with the discontinuation of treatment in 1% or more of Namenda-treated patients and at a rate greater than placebo.

Adverse Events Reported in Controlled Trials: The reported adverse events in Namenda (memantine hydrochloride) trials reflect experience gained under closely monitored conditions in a highly selected patient population. In actual practice or in other clinical trials, these frequency estimates may not apply, as the conditions of use, reporting behavior and the types of patients treated may differ. Table 1 lists treatment-emergent signs and symptoms that were reported in at least 2% of patients in placebo-controlled dementia trials and for which the rate of occurrence was greater for patients treated with Namenda than for those treated with placebo. No adverse event occurred at a frequency of at least 5% and twice the placebo rate.

Table 1: Adverse Events Reported in Controlled Clinical Trials in at Least 2% of Patients Receiving Namenda and at a Higher Frequency than Placebo-treated Patients.

Body System Adverse Event	Placebo (N = 922) %	Namenda (N = 940) %
Body as a Whole		
Fatigue	1	2
Pain	1	3
Cardiovascular System		
Hypertension	2	4
Central and Peripheral Nervous System		
Dizziness	5	7
Headache	3	6
Gastrointestinal System		
Constipation	3	5
Vomiting	2	3
Musculoskeletal System		
Back pain	2	3
Psychiatric Disorders		
Confusion	5	6
Somnolence	2	3
Hallucination	2	3
Respiratory System		
Coughing	3	4
Dyspnea	1	2

Other adverse events occurring with an incidence of at least 2% in Namenda-treated patients but at a greater or equal rate on placebo were agitation, fall, inflicted injury, urinary incontinence, diarrhea, bronchitis, insomnia, urinary tract infection, influenza-like symptoms, abnormal gait, depression, upper respiratory tract infection, anxiety, peripheral edema, nausea, anorexia, and arthralgia.

The overall profile of adverse events and the incidence rates for individual adverse events in the subpopulation of patients with moderate to severe Alzheimer's disease were not different from the profile and incidence rates described above for the overall dementia population.

Vital Sign Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, diastolic blood pressure, and weight) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. There were no clinically important changes in vital signs in patients treated with Namenda. A comparison of supine and standing vital sign measures for Namenda and placebo in elderly normal subjects indicated that Namenda treatment is not associated with orthostatic changes.

Laboratory Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Namenda treatment.

ECG Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in ECG parameters associated with Namenda treatment.

Other Adverse Events Observed During Clinical Trials
Namenda has been administered to approximately 1350 patients with dementia, of whom more than 1200 received the maximum recommended dose of 20 mg/day. Patients received Namenda treatment for periods of up to 884 days, with 862 patients receiving at least 24 weeks of treatment and 387 patients receiving 48 weeks or more of treatment.

Treatment emergent signs and symptoms that occurred during 8 controlled clinical trials and 4 open-label trials were recorded as adverse events by the clinical investigators using terminology of their own choosing. To provide an overall estimate of the proportion of individuals having similar types of events, the events were grouped into a smaller number of standardized categories using WHO terminology, and event frequencies were calculated across all studies.

All adverse events occurring in at least two patients are included, except for those already listed in Table 1, WHO terms too general to be informative, minor symptoms or events unlikely to be drug-caused, e.g., because they are common in the study population. Events are classified by body system and listed using the following definitions: frequent adverse events - those occurring in at least 1/100 patients; infrequent adverse events - those occurring in 1/100 to 1/1000 patients. These adverse events are not necessarily related to Namenda treatment and in most cases were observed at a similar frequency in placebo-treated patients in the controlled studies.

Body as a Whole: *Frequent:* syncope. *Infrequent:* hypothermia, allergic reaction.

Cardiovascular System: *Frequent:* cardiac failure. *Infrequent:* angina pectoris, bradycardia, myocardial infarction, thrombophlebitis, atrial fibrillation, hypotension, cardiac arrest, postural hypotension, pulmonary embolism, pulmonary edema.

Central and Peripheral Nervous System: *Frequent:* transient ischemic attack, cerebrovascular accident, vertigo, ataxia, hypokinesia. *Infrequent:* paresthesia, convulsions, extrapyramidal disorder, hypertonia, tremor, aphasia, hypoesthesia, abnormal coordination, hemiplegia, hyperkinesia, involuntary muscle contractions, stupor, cerebral hemorrhage, neuralgia, ptosis, neuropathy.

Gastrointestinal System: *Infrequent:* gastroenteritis, diverticulitis, gastrointestinal hemorrhage, melena, esophageal ulceration.

Hemic and Lymphatic Disorders: *Frequent:* anemia. *Infrequent:* leukopenia.

Metabolic and Nutritional Disorders: *Frequent:* increased alkaline phosphatase, decreased weight. *Infrequent:* dehydration, hyponatremia, aggravated diabetes mellitus.

Psychiatric Disorders: *Frequent:* aggressive reaction. *Infrequent:* delusion, personality disorder, emotional lability, nervousness, sleep disorder, libido increased, psychosis, amnesia, apathy, paranoid reaction, thinking abnormal, crying abnormal, appetite increased, paroniria, delirium, depersonalization, neurosis, suicide attempt.

Respiratory System: *Frequent:* pneumonia. *Infrequent:* apnea, asthma, hemoptysis.

Skin and Appendages: *Frequent:* rash. *Infrequent:* skin ulceration, pruritus, cellulitis, eczema, dermatitis, erythematous rash, alopecia, urticaria.

Special Senses: *Frequent:* cataract, conjunctivitis. *Infrequent:* macula lutea degeneration, decreased visual acuity, decreased hearing, tinnitus, blepharitis, blurred vision, corneal opacity, glaucoma, conjunctival hemorrhage, eye pain, retinal hemorrhage, xerophthalmia, diplopia, abnormal lacrimation, myopia, retinal detachment.

Urinary System: *Frequent:* frequent micturition. *Infrequent:* dysuria, hematuria, urinary retention.

Events Reported Subsequent to the Marketing of Namenda, both US and Ex-US
Although no causal relationship to memantine treatment has been found, the following adverse events have been reported to be temporally associated with memantine treatment and are not described elsewhere in labeling: atrioventricular block, bone fracture, carpal tunnel syndrome, cerebral infarction, chest pain, claudication, colitis, dyskinesia, dysphagia, gastritis, gastroesophageal reflux, grand mal convulsions, intracranial hemorrhage, hepatic failure, hyperlipidemia, hypoglycemia, ileus, impotence, malaise, neuroleptic malignant syndrome, acute pancreatitis, aspiration pneumonia, acute renal failure, prolonged QT interval, restlessness, Stevens-Johnson syndrome, sudden death, supraventricular tachycardia, tachycardia, tardive dyskinesia, and thrombocytopenia.

ANIMAL TOXICOLOGY
Memantine induced neuronal lesions (vacuolation and necrosis) in the multipolar and pyramidal cells in cortical layers III and IV of the posterior cingulate and retrosplenial neocortices in rats, similar to those which are known to occur in rodents administered other NMDA receptor antagonists. Lesions were seen after a single dose of memantine. In a study in which rats were given daily oral doses of memantine for 14 days, the no-effect dose for neuronal necrosis was 6 times the maximum recommended human dose on a mg/m² basis. The potential for induction of central neuronal vacuolation and necrosis by NMDA receptor antagonists in humans is unknown.

DRUG ABUSE AND DEPENDENCE
Controlled Substance Class: Memantine HCl is not a controlled substance.

Physical and Psychological Dependence: Memantine HCl is a low to moderate affinity uncompetitive NMDA antagonist that did not produce any evidence of drug-seeking behavior or withdrawal symptoms upon discontinuation in 2,504 patients who participated in clinical trials at therapeutic doses. Post marketing data, outside the U.S., retrospectively collected, has provided no evidence of drug abuse or dependence.

OVERDOSAGE
Because strategies for the management of overdose are continually evolving, it is advisable to contact a poison control center to determine the latest recommendations for the management of an overdose of any drug. As in any cases of overdose, general supportive measures should be utilized, and treatment should be symptomatic. Elimination of memantine can be enhanced by acidification of urine. In a documented case of an overdosage with up to 400 mg of memantine, the patient experienced restlessness, psychosis, visual hallucinations, somnolence, stupor and loss of consciousness. The patient recovered without permanent sequelae.

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Postpartum Depression Research Could Get Funding Boost

The House of Representatives passes legislation to increase support for new mothers who are affected by postpartum psychiatric disorders.

BY RICH DALY

The House of Representatives passed APA-supported legislation last month to expand services and research that target postpartum depression.

The Melanie Blocker-Stokes Postpartum Depression and Care Act (HR 20) would promote research and treatment for appropriate care of women with postpartum depression and postpartum psychosis through grants from the National Institutes of Health (NIH).

The bill, sponsored by Rep. Bobby Rush (D-Ill.), passed 382-3.

"The causes of postpartum depression are complex and unknown at this time," said Rep. Frank Pallone Jr. (D-N.J.) during a May congressional hearing on the bill. "However, if diagnosed properly and treated with social support, therapy, and medication, relief is highly attainable."

The measure also aims to improve the dissemination of guidelines for diagnosing and treating postpartum depression and related disorders to "health care professionals and the public."

Postpartum mood and anxiety disorders affect up to 18 percent of new mothers, and postpartum psychosis strikes 1 in 1,000 new mothers, according to the Centers for Disease Control and Prevention and other researchers.

The legislation is designed to address the range of postpartum mental health problems, which include the relatively mild "maternity blues" or "baby blues" to "devastating" postpartum psychosis. Between these two extremes is postpartum depression, the bill notes, which complicates 10 percent to 15 percent of all births and 26 percent to 32 percent of births by adolescents.

The legislation would authorize $3 million in research grants in the first year and unspecified sums thereafter. The Congressional Budget Office estimates that $18 million in grants would be awarded between 2008 and 2012.

The bill would support research such as epidemiological studies, the development of improved diagnostic techniques, clinical research, and information and education programs.

Although research suggests that many factors may contribute to the onset of postpartum depression, including hormonal changes, situational risks, and life stresses, more study is needed to clarify the condition's etiology, according to the bill's authors.

Stotland Testifies on Bill

"The bill lays out a straightforward agenda for research, resource coordination, and improved services to improve the diagnosis and treatment of postpartum depression, and—most importantly—to fund programs to establish and operate programs and systems of care for treating postpartum depression and postpartum psychosis," said Nada Stotland, M.D., APA president-elect, in testimony on the bill in May.

Stotland stressed that the type of clinical depression that may occur after childbirth can be an agonizing and disabling disorder impacting the general and mental health of the mother as well as the entire family.

The legislation also aims to increase detection of postpartum depression by improving clinicians' training and awareness of signs and symptoms and encouraging more women to seek treatment, rather than avoid it because of social stigma or embarrassment.

The bill urges a new national awareness campaign, in addition to NIH's current efforts, to inform the public about emerging research from the field. Both the NIH and the Health Resources and Services Administration sponsor Web sites on postpartum depression.

Treatment Programs Also Supported

In addition, the bill would establish a funding mechanism for establishing and operating systems of care for treating patients with postpartum depression and postpartum psychosis through grants to public and nonprofit programs that provide health care and support services. These programs would provide postpartum mental health care through inpatient and outpatient treatment, screenings, and case-management services.

The legislation also includes language that calls for a study on abortion- and miscarriage-related depression, which was added as a compromise amendment to satisfy some Republican lawmakers who raised the issue during a hearing on the bill.

The Senate companion bill (S 1375), which does not include the abortion provision, has not yet begun to advance.

The text of the Melanie Blocker-Stokes Postpartum Depression and Care Act can be accessed at <http://thomas.loc.gov> by searching on the bill number, HR 20. ■

SCHIP Advocates Still Trying For Veto-Proof Majority

Congressional supporters of the recently vetoed expansion of SCHIP are considering changes to the proposal, including a lower income–qualification cap, to add support for a future vote on the bill.

BY RICH DALY

After Democrats were unable to garner the votes necessary to override President Bush's veto of the State Children's Health Insurance Program (SCHIP) legislation, congressional leaders shifted to an attrition strategy to build support for the legislation over the coming weeks and months.

Democratic congressional leaders plan to hold regular votes on their bill to reauthorize and expand SCHIP to pressure a small group of Democrats and Republicans who opposed the bill to change their position. In mid-October Congress fell 18 votes short of overriding Bush's veto of the SCHIP bill (HR 976), which would have expanded the eligible population. Bush opposed the legislation because he thought it would have been too expensive and because of the provision to fund the expanded coverage through a 61-cent-per-pack increase in the federal tobacco tax.

At press time, Democratic leaders were in negotiations with Republicans to gain veto-proof support for differing versions approved by both chambers in late October and early November.

Over the next five years, the vetoed bill would have provided an additional $35 billion in funding for the program and increase total SCHIP spending to $60 billion.

The House considered a modified bill in October capping eligibility at 300 percent of the federal poverty level in all states. The vetoed version gave high-income states the option of setting a higher income ceiling. The modified bill also would give states greater authority to assess the validity of applicants' Social Security numbers to confirm their U.S. residency status.

Some Republicans requested changes that would apply the same proof-of-citizenship rules used by Medicaid to SCHIP. Critics, including APA, have maintained, however, that those rules make it difficult for many Medicaid-eligible individuals to apply for that program.

The bill—as revised in October—also would phase out childless adults from SCHIP within one year, instead of the two years allowed in the vetoed bill. The provision aims to end the Department of Health and Human Services' practice of allowing states to use unspent SCHIP funds to provide insurance coverage for some low-income, childless adults.

Moderate Republicans such as Reps. Ray LaHood (Ill.), Fred Upton (Mich.), Charles Dent (Pa.), and Michael Castle (Del.), met with Democratic leaders to discuss changes to the bill that might garner additional GOP support.

Republicans urged three changes that would likely boost support among members of their party. They said that the legislation needs a greater focus on covering children in families with annual incomes less than 200 percent of the poverty level, more antifraud measures and stronger mechanisms for keeping illegal immigrants out of SCHIP, and discouraging families from dropping private insurance coverage to enroll in SCHIP, which is referred to as "crowd-out" (*Psychiatric News*, September 21).

Ways and Means Committee Chair Charles Rangel (D-N.Y.) has said that a revised bill needs to make explicit that children from high-income families and illegal immigrants are not eligible for SCHIP.

Narrowing eligibility to 200 percent of the poverty level likely would, however, result in fewer than 10 million children receiving coverage under the program, which is why Democrats would not likely support such a provision. House Speaker Nancy Pelosi (D-Calif.) repeated in multiple interviews that she would not support any changes that would cut a significant number of the 10 million children projected to receive insurance coverage under the vetoed bill.

The Senate passed an amended bill with a veto-proof majority.

There has been an intense public-relations battle over the fate of SCHIP, and in October Democrats seemed to be winning the fight. About half of Americans say they have more confidence in the Democrats in Congress than in Bush to handle the issue, according to a mid-October *USA Today*/Gallup poll. Only one-third of Americans thought Bush had the better position on this issue, while 15 percent said they had no preference.

However, Americans are also generally sympathetic to Bush's concern about the program leading to what he called "socialized" medical care in the United States. Fifty-five percent say they were very or somewhat concerned that expanding the program would create an incentive for middle-class Americans to drop their private health insurance to enroll in the publicly funded program. ■

Substance Abuse Codes Added

The White House Office of National Drug Control Policy (ONDCP) has announced publication of new *Current Precedural Terminology* codes for substance abuse screening (except tobacco) and brief intervention. The codes, issued by the AMA, are 99408 and 99409 and will go into effect on January 1.

"These new health care codes will strengthen the doctor-patient relationship and incorporate a powerful preventive public health resource in America's health care system," stated ONDCP Deputy Director Bertha K. Madras, M.D.

Further information is posted at <www.whitehousedrugpolicy.gov/>. ■

Anxiety disorders often other comorbid conditions[1]

*In patients with **social anxiety disorder (SAD)** and a comorbid psychiatric disorder...*

In a study, SAD preceded the disorder in more than 75% of cases[3]

Facts about SAD

- One of the most common anxiety disorders[1]
- Affects approximately 15 million American adults—about the same amount affected by major depressive disorder[1]
- A lifetime prevalence of over 13%[4]
- Frequently not identified[5]

SAD patients have an increased risk of developing[3]:

- Obsessive compulsive disorder
- Major depressive disorder
- Panic disorder
- Drug and alcohol dependency

References: 1. Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month *DSM-IV* disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62:617-627. **2.** National Institute of Mental Health. The Numbers Count: Mental Disorders In America. http://www.nimh.nih.gov/publicat/numbers.cfm#MajorDepressive. Accessed August 30, 2007. **3.** Schneier FR, Johnson J, Hornig CD, Liebowitz MR, Weissman MM. Social phobia: comorbidity and morbidity in an epidemiologic sample. *Arch Gen Psychiatry*. 1992;49:282-288. **4.** Magee WJ, Eaton WW, Wittchen H-U, McGonagle KA, Kessler RC. Agoraphobia, simple phobia, and social phobia in the National Comorbidity Survey. *Arch Gen Psychiatry*. 1996;53:159-168. **5.** Connor KM, Kobak KA, Churchill LE, Katzelnick D, Davidson JRT. Mini-Spin: a brief screening assessment for generalized social anxiety disorder. *Depress Anxiety*. 2001;14:137-140. **6.** Abramowitz JS, Storch EA, Keeley M, Cordell E. Obsessive-compulsive disorder with comorbid major depression: what is the role of cognitive factors? *Behav Res Ther*. In press. **7.** Obsessive-Compulsive Disorder. In: Sadock BJ, Sadock VA, eds. *Synopsis of Psychiatry*. 9th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2003:616-623. **8.** Obsessive-Compulsive Disorder. In: Hales RE, Yudofsky SC, Talbott JA, eds. *Textbook of Psychiatry*. 3rd ed. Washington, DC: American Psychiatric Press, Inc. 1999:600-610. **9.** American Psychiatric Association. Practice guideline for the treatment of patients with obsessive-compulsive disorder. http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm. Accessed August 21, 2007.

present first, before

AFFECTING MORE THAN 40 MILLION AMERICAN ADULTS EACH YEAR[2]

*In patients with **obsessive compulsive disorder (OCD)** and comorbid depression...*

OCD preceded the disorder, suggesting that mood disturbances may occur as a response to the functional impairment of OCD[6]

Facts about OCD

- Affects about 2.2 million American adults[1]
- 67% of patients will have an associated lifetime diagnosis of major depressive disorder[7]
- Can be misdiagnosed as depression, psychosis, phobias, or personality disorder[8]

OCD symptoms can be accompanied by[9]:

- Eating disorders
- Other anxiety disorders
- Major depressive disorder
- Alcohol or drug abuse

Early recognition and treatment of anxiety disorders are an important part of successful therapy

Jazz Pharmaceuticals®
Innovation that performs

Psychiatry Residents Paint Over Katrina's Destruction

The urge to help Louisiana's mental health facilities reopen motivates psychiatry residents to provide treatment of a very different sort.

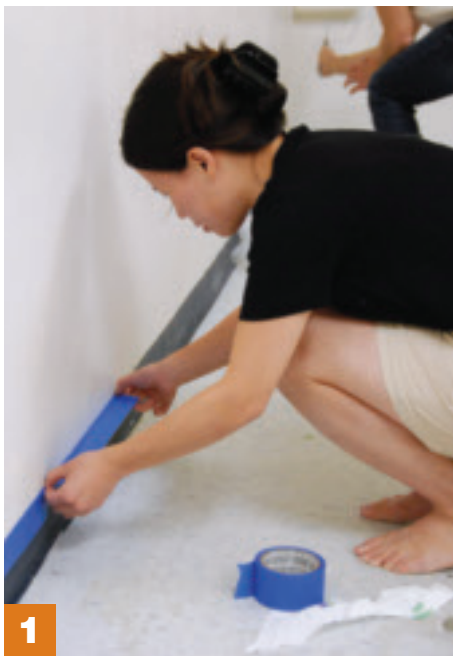
BY AARON LEVIN

Responsibility House in the Marrero section of New Orleans is a 24-hour, residential, social detoxification facility for persons with severe and persistent mental illness, especially those who are homeless or have HIV. Like many mental health facilities in the area, it closed following Hurricane Katrina, but it is now in the final stages of being repaired.

APA member Suzanne Vogel-Scibilia, M.D., immediate past president of the National Alliance on Mental Illness, helped organize groups of volunteers attending APA's Institute on Psychiatric Services in October to go to Responsibility House and finish painting the center. She received some financial support from the American Association of Community Psychiatrists, which was meeting in New Orleans at APA's institute.

This day, the group was composed of APA/Bristol-Myers Squibb fellows in public psychiatry. Why did they come? Allison Nitsche, M.D., now a combined child and community psychiatry fellow at Emory University in Atlanta, is from New Orleans and volunteered in the Houston Astrodome immediately after Katrina struck. When she returned to New Orleans, she saw that the house she had lived in during medical school had been flooded up to the roof.

"I just wanted to help out while I was here and to work with my colleagues," she said. "I have a lot of admiration for people who stayed here and continued their training. I hope to come back when I'm finished with mine." ■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1 Trina Chang, M.D., M.P.H., a resident at Massachusetts General Hospital and McLean Hospital.
2 "I'm interested in disaster and post-conflict psychiatry," said Sonali Sharma, M.D., M.Sc. "My goal was to focus on what is important, to see the effects of the storm and contribute to rebuilding."
3 Tony Carino, M.D., a PGY-4 resident at Albert Einstein College of Medicine in the Bronx, N.Y.
4 Chantelle Simmons, M.D., PGY-3 resident at Emory. "I wanted to help people after the hurricane, so I worked with the Red Cross in Atlanta doing mental health assessments. I'm painting the walls here because I think if you can do something, you have to do it."
5 Besides his expertise in disaster psychiatry, Joseph Napoli, M.D., of Fort Lee, N.J., retains the skills in carpentry, plumbing, and electricity picked up in his youth from talented uncles. "Psychiatrists help people in many ways, and volunteering is one of those many ways," he said.
6 Kate Rye, D.O., a PGY-3 resident at Northwestern, and Patrick Runnels, M.D., a fellow in community psychiatry.

Photos: Aaron Levin

Because she does not like to compromise…

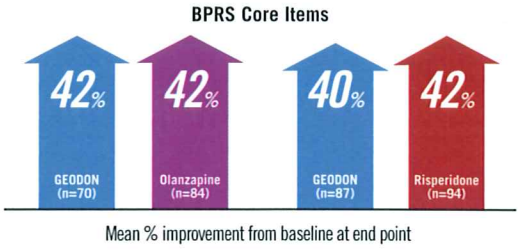

mind
body

IN SCHIZOPHRENIA

Treat With the Body in Mind

CHOOSE COMPARABLE POWER...

Consistent results in acute head-to-head studies[1-3]



A 6-week, double-blind, randomized study of GEODON vs olanzapine and an 8-week, double-blind, randomized study of GEODON vs risperidone.

- BPRS core items include hallucinatory behavior, unusual thought content, conceptual disorganization, and suspiciousness
- Comparable efficacy was maintained in double-blind extension studies
  —up to 1 year vs risperidone[1]
  —up to 6 months vs olanzapine[4]

...WITHOUT COMPROMISING METABOLIC PARAMETERS

Significant results in switch studies after 1 year[1,5]

Two 1-year open-label extensions of 6-week, open-label switch studies in patients suboptimally controlled due to partial response or poor tolerability.

- Patients switching to GEODON from olanzapine and risperidone also experienced reductions in triglycerides[5]

In the acute head-to-head studies...

- In the GEODON vs olanzapine study, olanzapine significantly increased body weight (8 lb vs 2 lb for GEODON, $P<0.0001$)[1,2]
- In the GEODON vs risperidone study, risperidone increased body weight (2 lb vs 0 lb for GEODON, $P<0.01$)[1,3]

CHOOSE GEODON® (ziprasidone HCl) Oral Capsules

GEODON is indicated for the treatment of acute manic or mixed episodes associated with bipolar disorder and for the treatment of schizophrenia.

Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. GEODON is not approved for the treatment of patients with dementia-related psychosis.

GEODON is contraindicated in patients with a known history of QT prolongation, recent acute myocardial infarction, or uncompensated heart failure, and should not be used with other QT-prolonging drugs. GEODON has a greater capacity to prolong the QT_c interval than several antipsychotics. In some drugs, QT prolongation has been associated with torsade de pointes, a potentially fatal arrhythmia. In many cases this would lead to the conclusion that other drugs should be tried first.

As with all antipsychotic medications, a rare and potentially fatal condition known as neuroleptic malignant syndrome (NMS) has been reported with GEODON. NMS can cause hyperpyrexia, muscle rigidity, diaphoresis, tachycardia, irregular pulse or blood pressure, cardiac dysrhythmia, and altered mental status. If signs and symptoms appear, immediate discontinuation, treatment, and monitoring are recommended.

Prescribing should be consistent with the need to minimize tardive dyskinesia (TD), a potentially irreversible dose- and duration-dependent syndrome. If signs and symptoms appear, discontinuation should be considered since TD may remit partially or completely.

Hyperglycemia-related adverse events, sometimes serious, have been reported in patients treated with atypical antipsychotics. There have been few reports of hyperglycemia or diabetes in patients treated with GEODON, and it is not known if GEODON is associated with these events. Patients treated with an atypical antipsychotic should be monitored for symptoms of hyperglycemia.

Precautions include the risk of rash, orthostatic hypotension, and seizures.

The most common adverse events associated with GEODON in bipolar mania were somnolence, extrapyramidal symptoms, dizziness, akathisia, and abnormal vision.

In short-term schizophrenia trials, the most commonly observed adverse events associated with GEODON at an incidence of ≥5% and at least twice the rate of placebo were somnolence and respiratory tract infection.

In short-term schizophrenia clinical trials, 10% of GEODON-treated patients experienced a weight gain of ≥7% of body weight vs 4% for placebo.

Pfizer

Please see brief summary of prescribing information, including boxed warning, on adjacent page.

BRIEF SUMMARY. See package insert for full prescribing information.

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

INDICATIONS—GEODON Capsules is indicated for the treatment of schizophrenia and acute manic or mixed episodes associated with bipolar disorder with or without psychotic features. GEODON® (ziprasidone mesylate) for Injection is indicated for acute agitation in schizophrenic patients.

CONTRAINDICATIONS — *QT Prolongation:* Because of GEODON's dose-related prolongation of the QT interval and the known association of fatal arrhythmias with QT prolongation by some other drugs, GEODON is contraindicated in patients with a known history of QT prolongation (including congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure (see **WARNINGS**). Pharmacokinetic/pharmacodynamic studies between GEODON and other drugs that prolong the QT interval have not been performed. An additive effect of GEODON and other drugs that prolong the QT interval cannot be excluded. Therefore, GEODON should not be given with dofetilide, sotalol, quinidine, other Class Ia and III anti-arrhythmics, mesoridazine, thioridazine, chlorpromazine, droperidol, pimozide, sparfloxacin, gatifloxacin, moxifloxacin, halofantrine, mefloquine, pentamidine, arsenic trioxide, levomethadyl acetate, dolasetron mesylate, probucol, or tacrolimus. GEODON is also contraindicated with drugs that have demonstrated QT prolongation as one of their pharmacodynamic effects and have this effect described in the full prescribing information as a contraindication or a boxed or bolded warning (see **WARNINGS**). GEODON is contraindicated in individuals with a known hypersensitivity to the product. **WARNINGS—Increased Mortality in Elderly Patients with Dementia-Related Psychosis: Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. GEODON (ziprasidone) is not approved for the treatment of patients with dementia-related psychosis (see Boxed Warning). *QT Prolongation and Risk of Sudden Death:*** **GEODON use should be avoided in combination with other drugs that are known to prolong the QT_c interval. Additionally, clinicians should be alert to the identification of other drugs that have been consistently observed to prolong the QT_c interval. Such drugs should not be prescribed with GEODON. A study directly comparing the QT/QT_c-prolonging effect of GEODON with several other drugs effective in the treatment of schizophrenia was conducted in patient volunteers. The mean increase in QT_c from baseline for GEODON ranged from approximately 9 to 14 msec greater than for four of the comparator drugs (risperidone, olanzapine, quetiapine, and haloperidol), but was approximately 14 msec less than the prolongation observed for thioridazine. In this study, the effect of GEODON on QT_c length was not augmented by the presence of a metabolic inhibitor (ketoconazole 200 mg bid). In placebo-controlled trials, GEODON increased the QT_c interval compared to placebo by approximately 10 msec at the highest recommended daily dose of 160 mg. In clinical trials the electrocardiograms of 2/2988 (0.06%) GEODON patients and 1/440 (0.23%) placebo patients revealed QT_c intervals exceeding the potentially clinically relevant threshold of 500 msec. In the GEODON patients, neither case suggested a role of GEODON. Some drugs that prolong the QT/QT_c interval have been associated with the occurrence of torsade de pointes and with sudden unexplained death. The relationship of QT prolongation to torsade de pointes is clearest for larger increases (20 msec and greater) but it is possible that smaller QT/QT_c prolongations may also increase risk, or increase it in susceptible individuals, such as those with hypokalemia, hypomagnesemia, or genetic predisposition. Although torsade de pointes has not been observed in association with the use of GEODON at recommended doses in premarketing studies, experience is too limited to rule out an increased risk. A study evaluating the QT/QT_c prolonging effect of intramuscular GEODON, with intramuscular haloperidol as a control, was conducted in patient volunteers. In the trial, ECGs were obtained at the time of maximum plasma concentration following two injections of GEODON (20 mg then 30 mg) or haloperidol (7.5 mg then 10 mg) given four hours apart. Note that a 30 mg dose of intramuscular GEODON is 50% higher than the recommended therapeutic dose. The mean change in QT_c from baseline was calculated for each drug using a sample-based correction that removes the effect of heart rate on the QT interval. The mean increase in QT_c from baseline for GEODON was 4.6 msec following the first injection and 12.8 msec following the second injection. The mean increase in QT_c from baseline for haloperidol was 6.0 msec following the first injection and 14.7 msec following the second injection. In this study, no patient had a QT_c interval exceeding 500 msec. As with other antipsychotic drugs and placebo, sudden unexplained deaths have been reported in patients taking GEODON at recommended doses. The premarketing experience for GEODON did not reveal an excess of mortality for GEODON compared to other antipsychotic drugs or placebo, but the extent of exposure was limited, especially for the drugs used as active controls and placebo. Nevertheless, GEODON's larger prolongation of QT_c length compared to several other antipsychotic drugs raises the possibility that the risk of sudden death may be greater for GEODON than for other available drugs for treating schizophrenia. This possibility needs to be considered in deciding among alternative drug products. Certain circumstances may increase the risk of the occurrence of torsade de pointes and/or sudden death in association with the use of drugs that prolong the QT_c interval, including (1) bradycardia; (2) hypokalemia or hypomagnesemia; (3) concomitant use of other drugs that prolong the QT_c interval; and (4) presence of congenital prolongation of the QT interval. GEODON should also be avoided in patients with congenital long QT syndrome and in patients with a history of cardiac arrhythmias (see CONTRAINDICATIONS, and see *Drug Interactions* under PRECAUTIONS). It is recommended that patients being considered for GEODON treatment who are at risk for significant electrolyte disturbances, hypokalemia in particular, have baseline serum potassium and magnesium measurements. Hypokalemia (and/or hypomagnesemia) may increase the risk of QT prolongation and arrhythmia. Hypokalemia may result from diuretic therapy, diarrhea, and other causes. Patients with low serum potassium and/or magnesium should be repleted with those electrolytes before proceeding with treatment. It is essential to periodically monitor serum electrolytes in patients for whom diuretic therapy is introduced during GEODON treatment. Persistently prolonged QT_c intervals may also increase the risk of further prolongation and arrhythmia, but it is not clear that routine screening ECG measures are effective in detecting such patients. Rather, GEODON should be avoided in patients with histories of significant cardiovascular illness, eg, QT prolongation, recent acute myocardial infarction, uncompensated heart failure, or cardiac arrhythmia. GEODON should be discontinued in patients who are found to have persistent QT_c measurements >500 msec. *Neuroleptic Malignant Syndrome (NMS):*** A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with administration of antipsychotic drugs. 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. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored, since recurrences of NMS have been reported. ***Tardive Dyskinesia (TD):*** A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients undergoing treatment with antipsychotic drugs. Although the prevalence of TD 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 TD. If signs and symptoms of TD appear in a patient on GEODON, drug discontinuation should be considered. ***Hyperglycemia and Diabetes Mellitus:*** Hyperglycemia-related adverse events, sometimes serious, have been reported in patients treated with atypical antipsychotics. There have been few reports of hyperglycemia or diabetes in patients treated with GEODON, and it is not known if GEODON is associated with these events. Patients treated with an atypical antipsychotic should be monitored for symptoms of hyperglycemia. **PRECAUTIONS — *General:*** Rash: In premarketing trials, about 5% of GEODON patients developed rash and/or urticaria, with discontinuation of treatment in about one-sixth of these cases. The occurrence of rash was dose related, although the finding might also be explained by longer exposure in higher-dose patients. Several patients with rash had signs and symptoms of associated systemic illness, e.g., elevated WBCs. Most patients improved promptly upon treatment with antihistamines or steroids and/or upon discontinuation of GEODON, and all patients were reported to recover completely. Upon appearance of rash for which an alternative etiology cannot be identified, GEODON should be discontinued. Orthostatic Hypotension: GEODON may induce orthostatic hypotension associated with dizziness, tachycardia, and, in some patients, syncope, especially during the initial dose-titration period, probably reflecting its α_1-adrenergic antagonist properties. Syncope was reported in 0.6% of GEODON patients. GEODON should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease or conditions that would predispose patients to hypotension (dehydration, hypovolemia, and treatment with antihypertensive medications). Seizures: In clinical trials, seizures occurred in 0.4% of GEODON patients. There were confounding factors that may have contributed to seizures in many of these cases. As with other antipsychotic drugs, GEODON should be used cautiously in patients with a history of seizures or with conditions that potentially lower the seizure threshold, e.g., Alzheimer's dementia. Conditions that lower the seizure threshold may be more prevalent in a population of 65 years or older. 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, and GEODON and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia. **(See also Boxed WARNING, WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis)** Hyperprolactinemia: As with other drugs that antagonize dopamine D_2 receptors, GEODON elevates prolactin levels in humans. 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 contemplated in a patient with previously detected breast cancer. 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; the available evidence is considered too limited to be conclusive at this time. Potential for Cognitive and Motor Impairment: Somnolence was a commonly reported adverse event in GEODON patients. In the 4- and 6-week placebo-controlled trials, somnolence was reported in 14% of GEODON patients vs 7% of placebo patients. Somnolence led to discontinuation in 0.3% of patients in short-term clinical trials. Since GEODON has the potential to impair judgment, thinking, or motor skills, patients should be cautioned about performing activities requiring mental alertness, such as operating a motor vehicle (including automobiles) or operating hazardous machinery until they are reasonably certain that GEODON therapy does not affect them adversely. Priapism: One case of priapism was reported in the premarketing database. Body Temperature Regulation: Although not reported with GEODON in premarketing trials, disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Suicide: The possibility of a suicide attempt is inherent in psychotic illness and close supervision of high-risk patients should accompany drug therapy. GEODON prescriptions should be written for the smallest quantity of capsules consistent with good patient management to reduce overdose risk. Use in Patients with Concomitant Illness: Clinical experience with GEODON in patients with certain concomitant systemic illnesses is limited. GEODON has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from premarketing clinical studies. Because of the risk of QT prolongation and orthostatic hypotension with GEODON, caution should be observed in cardiac patients (see ***QT Prolongation and Risk of Sudden Death*** in **WARNINGS** and Orthostatic Hypotension in **PRECAUTIONS**). ***Information for Patients:*** To ensure safe and effective use of GEODON, the information and instructions in the *Patient Information Section* should be discussed with patients. ***Laboratory Tests:*** Patients being considered for GEODON treatment who are at risk of significant electrolyte disturbances should have baseline serum potassium and magnesium measurements. Low serum potassium and magnesium should be repleted before treatment. Patients who are started on diuretics during GEODON therapy need periodic monitoring of serum potassium and magnesium. Discontinue GEODON in patients who are found to have persistent QT_c measurements >500 msec (see **WARNINGS**). ***Drug Interactions:*** (1) GEODON should not be used with any drug that prolongs the QT interval. (2) Given the primary CNS effects of GEODON, caution should be used when it is taken in combination with other centrally acting drugs. (3) Because of its potential for inducing hypotension, GEODON may enhance the effects of certain antihypertensive agents. (4) GEODON may antagonize the effects of levodopa and dopamine agonists. Effect of Other Drugs on GEODON: *Carbamazepine*, 200 mg bid for 21 days, resulted in a decrease of approximately 35% in the AUC of GEODON. *Ketoconazole*, a potent inhibitor of CYP3A4, 400 mg qd for 5 days, increased the AUC and C_{max} of GEODON by about 35%-40%. *Cimetidine*, 800 mg qd for 2 days, did not affect GEODON pharmacokinetics. Coadministration of 30 mL of *Maalox* did not affect GEODON pharmacokinetics. Population pharmacokinetic analysis of schizophrenic patients in controlled clinical trials has not revealed any clinically significant pharmacokinetic interactions with benztropine, propranolol, or lorazepam. Effect of GEODON on Other Drugs: In vitro studies revealed little potential for GEODON to interfere with the metabolism of drugs cleared primarily by CYP1A2, CYP2C9, CYP2C19, CYP2D6, and CYP3A4, and little potential for drug interactions with GEODON due to displacement. GEODON 40 mg bid administered concomitantly with *lithium* 450 mg bid for 7 days did not affect the steady-state level or renal clearance of lithium. GEODON 20 mg bid did not affect the pharmacokinetics of concomitantly administered *oral contraceptives*, ethinyl estradiol (0.03 mg) and levonorgestrel (0.15 mg). Consistent with in vitro results, a study in normal healthy volunteers showed that GEODON did not alter the metabolism of *dextromethorphan*, a CYP2D6 model substrate, to its major metabolite, dextrorphan. There was no statistically significant change in the urinary dextromethorphan/dextrorphan ratio. ***Carcinogenesis, Mutagenesis, Impairment of Fertility:*** Lifetime carcinogenicity studies were conducted with GEODON in Long Evans rats and CD-1 mice. In male mice, there was no increase in incidence of tumors relative to controls. In female mice there were dose-related increases in the incidences of pituitary gland adenoma and carcinoma, and mammary gland adenocarcinoma at all doses tested. Increases in serum prolactin were observed in a 1-month dietary study in female, but not male, mice. GEODON had no effect on serum prolactin in rats in a 5-week dietary study at the doses that were used in the carcinogenicity study. The relevance for human risk of the findings of prolactin-mediated endocrine tumors in rodents is unknown (see Hyperprolactinemia). Mutagenesis: There was a reproducible mutagenic response in the Ames assay in one strain of *S. typhimurium* in the absence of metabolic activation. Positive results were obtained in both the in vitro mammalian cell gene mutation assay and the in vitro chromosomal aberration assay in human lymphocytes. Impairment of Fertility: GEODON increased time to copulation in Sprague-Dawley rats in two fertility and early embryonic development studies at doses of 10 to 160 mg/kg/day (0.5 to 8 times the MRHD of 200 mg/day on a mg/m^2 basis). Fertility rate was reduced at 160 mg/kg/day (8 times the MRHD on a mg/m^2 basis). There was no effect on fertility at 40 mg/kg/day (2 times the MRHD on a mg/m^2 basis). The fertility of female rats was reduced. ***Pregnancy—Pregnancy Category C:*** There are no adequate and well-controlled studies in pregnant women. GEODON should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. ***Labor and Delivery:*** The effect of GEODON on labor and delivery in humans is unknown. ***Nursing Mothers:*** It is not known whether, and if so in what amount, GEODON or its metabolites are excreted in human milk. It is recommended that women receiving GEODON should not breast feed. ***Pediatric Use:*** The safety and effectiveness of GEODON in pediatric patients have not been established. ***Geriatric Use:*** Of the approximately 4500 patients treated with GEODON in clinical studies, 2.4% (109) were 65 years of age or over. In general, there was no indication of any different tolerability for GEODON or of reduced clearance of GEODON in the elderly compared to younger adults. Nevertheless, the presence of multiple factors that might increase the pharmacodynamic response to GEODON, or cause poorer tolerance or orthostasis, should lead to consideration of a lower starting dose, slower titration, and careful monitoring during the initial dosing period for some elderly patients. **ADVERSE REACTIONS — *Adverse Findings Observed in Short-term, Placebo-Controlled Trials:*** The following findings are based on the short-term placebo-controlled premarketing trials for schizophrenia (a pool of two 6-week, and two 4-week fixed-dose trials) and bipolar mania (a pool of two 3-week flexible-dose trials) in which GEODON was administered in doses ranging from 10 to 200 mg/day. ***Adverse Events Associated with Discontinuation:*** Schizophrenia: Approximately 4.1% (29/702) of GEODON-treated patients in short-term, placebo-controlled studies discontinued treatment due to an adverse event, compared with about 2.2% (6/273) on placebo. The most common event associated with dropout was rash, including 7 dropouts for rash among GEODON patients (1%) compared to no placebo patients (see **PRECAUTIONS**). Bipolar Mania: Approximately 6.5% (18/279) of GEODON-treated patients in short-term, placebo-controlled studies discontinued treatment due to an adverse event, compared with about 3.7% (5/136) on placebo. The most common events associated with dropout in the GEODON-treated patients were akathisia, anxiety, depression, dizziness, dystonia, rash and vomiting, with 2 dropouts for each of these events among GEODON patients (1%) compared to one placebo patient each for dystonia and rash (1%) and no placebo patients for the remaining adverse events. ***Adverse Events at an Incidence ≥5% and at Least Twice the Rate of Placebo:*** The most commonly observed adverse events associated with GEODON in schizophrenia trials were somnolence (14%) and respiratory tract infection (8%). The most commonly observed adverse events associated with the use of GEODON in bipolar mania trials were somnolence (31%), extrapyramidal symptoms (31%), dizziness (16%), akathisia (10%), abnormal vision (6%), asthenia (6%), and vomiting (5%). The following list enumerates the treatment-emergent adverse events that occurred during acute therapy, including only those events that occurred in 2% of GEODON patients and at a greater incidence than in placebo. Schizophrenia: Body as a Whole—asthenia, accidental injury, chest pain. Cardiovascular—tachycardia. Digestive—nausea, constipation, dyspepsia, diarrhea, dry mouth, anorexia. Nervous—extrapyramidal symptoms, somnolence, akathisia, dizziness. Respiratory—respiratory tract infection, rhinitis, cough increased. Skin and Appendages—rash, fungal dermatitis. Special Senses—abnormal vision. Bipolar Mania: Body as a Whole—headache, asthenia, accidental injury. Cardiovascular—hypertension. Digestive—nausea, diarrhea, dry mouth, vomiting, increased salivation, tongue edema, dysphagia. Musculoskeletal—myalgia. Nervous—somnolence, extrapyramidal symptoms, dizziness, akathisia, anxiety, hypesthesia, speech disorder. Respiratory—pharyngitis, dyspnea. Skin and Appendages—fungal dermatitis. Special Senses—abnormal vision. ***Dose Dependency:*** An analysis for dose response in the schizophrenia trials revealed an apparent relation of adverse event to dose for the following: asthenia, postural hypotension, anorexia, dry mouth, increased salivation, arthralgia, anxiety, dizziness, dystonia, hypertonia, somnolence, tremor, rhinitis, rash, and abnormal vision. ***Extrapyramidal Symptoms (EPS):*** The incidence of reported EPS for GEODON patients in the short-term, placebo-controlled schizophrenia trials was 14% vs 8% for placebo. Objectively collected data from those trials on the Simpson-Angus Rating Scale and the Barnes Akathisia Scale did not generally show a difference between GEODON and placebo. ***Vital Sign Changes:*** GEODON is associated with orthostatic hypotension (see **PRECAUTIONS**). ***Weight Gain:*** In short-term schizophrenia trials, the proportions of patients meeting a weight gain criterion of ≥7% of body weight were compared, revealing a statistically significantly greater incidence of weight gain for GEODON patients (10%) vs placebo patients (4%). A median weight gain of 0.5 kg was observed in GEODON patients vs 0.0 kg in placebo patients. Weight gain was reported as an adverse event in 0.4% of both GEODON and placebo patients. During long-term therapy with GEODON, a categorization of patients at baseline on the basis of body mass index (BMI) showed the greatest mean weight gain and the highest incidence of clinically significant weight gain (>7% of body weight) in patients with a low BMI (<23) compared to normal (23-27) or overweight (>27) patients. There was a mean weight gain of 1.4 kg for patients with a "low" baseline BMI, 0.0 kg for patients with a "normal" BMI, and a 1.3 kg mean weight loss for patients with a "high" BMI. ***ECG Changes:*** GEODON is associated with an increase in the QT_c interval (see **WARNINGS**). In schizophrenia trials, GEODON was associated with a mean increase in heart rate of 1.4 beats per minute compared to a 0.2 beats per minute decrease among placebo patients. ***Other Adverse Events Observed During the Premarketing Evaluation of GEODON:*** Frequent adverse events are those occurring in at least 1/100 patients; infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. Schizophrenia: Body as a Whole — *Frequent:* abdominal pain, flu syndrome, fever, accidental fall, face edema, chills, photosensitivity reaction, flank pain, hypothermia, motor vehicle accident. Cardiovascular System — *Frequent:* tachycardia, hypertension, postural hypotension; *Infrequent:* bradycardia, angina pectoris, atrial fibrillation; *Rare:* first-degree AV block, bundle branch block, phlebitis, pulmonary embolus, cardiomegaly, cerebral infarct, cerebrovascular accident, deep thrombophlebitis, myocarditis, thrombophlebitis. Digestive System — *Frequent:* anorexia, vomiting; *Infrequent:* rectal hemorrhage, dysphagia, tongue edema; *Rare:* gum hemorrhage, jaundice, fecal impaction, gamma glutamyl transpeptidase increased, hematemesis, cholestatic jaundice, hepatitis, hepatomegaly, leukoplakia of mouth, fatty liver deposit, melena. Endocrine — *Rare:* hypothyroidism, hyperthyroidism, thyroiditis. Hemic and Lymphatic System — *Infrequent:* anemia, ecchymosis, leukocytosis, leukopenia, eosinophilia, lymphadenopathy; *Rare:* thrombocytopenia, hypochromic anemia, lymphocytosis, monocytosis, basophilia, lymphedema, polycythemia, thrombocythemia. Metabolic and Nutritional Disorders — *Infrequent:* thirst, transaminase increased, peripheral edema, hyperglycemia, creatine phosphokinase increased, alkaline phosphatase increased, hypercholesteremia, dehydration, lactic dehydrogenase increased, albuminuria, hypokalemia; *Rare:* BUN increased, creatinine increased, hyperlipemia, hypocholesteremia, hyperkalemia, hypochloremia, hypoglycemia, hyponatremia, hypoproteinemia, glucose tolerance decreased, gout, hyperchloremia, hyperuricemia, hypocalcemia, hypoglycemic reaction, hypomagnesemia, ketosis, respiratory alkalosis. Musculoskeletal System — *Frequent:* myalgia; *Infrequent:* tenosynovitis; *Rare:* myopathy. Nervous System — *Frequent:* agitation, extrapyramidal syndrome, tremor, dystonia, hypertonia, dyskinesia, hostility, twitching, paresthesia, confusion, vertigo, hypokinesia, hyperkinesia, abnormal gait, oculogyric crisis, hypesthesia, ataxia, amnesia, cogwheel rigidity, delirium, hypotonia, akinesia, dysarthria, withdrawal syndrome, buccoglossal syndrome, choreoathetosis, diplopia, incoordination, neuropathy; *Infrequent:* paralysis; *Rare:* myoclonus, nystagmus, torticollis, circumoral paresthesia, opisthotonos, reflexes increased, trismus. Respiratory System — *Frequent:* dyspnea; *Infrequent:* pneumonia, epistaxis; *Rare:* hemoptysis, laryngismus. Skin and Appendages — *Infrequent:* maculopapular rash, urticaria, alopecia, eczema, exfoliative dermatitis, contact dermatitis, vesiculobullous rash. Special Senses — *Frequent:* fungal dermatitis; *Infrequent:* conjunctivitis, dry eyes, tinnitus, blepharitis, cataract, photophobia; *Rare:* eye hemorrhage, visual field defect, keratitis, keratoconjunctivitis. Urogenital System — *Infrequent:* impotence, abnormal ejaculation, amenorrhea, hematuria, menorrhagia, female lactation, polyuria, urinary retention, metrorrhagia, male sexual dysfunction, anorgasmia, glycosuria; *Rare:* gynecomastia, vaginal hemorrhage, nocturia, oliguria, female sexual dysfunction, uterine hemorrhage. **Adverse Finding Observed in Trials of Intramuscular GEODON:** In these studies, the most commonly observed adverse events associated with the use of intramuscular GEODON (≥5%) and observed at a rate on intramuscular GEODON (in the higher dose groups) at least twice that of the lowest intramuscular GEODON group were headache (13%), nausea (12%), and somnolence (20%). **Adverse Events at an Incidence >1% in Short-Term Fixed-Dose Intramuscular Trials:** The following list enumerates the treatment-emergent adverse events that occurred in ≥1% of GEODON patients (in the higher dose groups) and at least twice that of the lowest intramuscular GEODON group. Body as a Whole — headache, injection site pain, asthenia, abdominal pain, flu syndrome, back pain. Cardiovascular — postural hypotension, hypertension, bradycardia, vasodilation. Digestive — nausea, rectal hemorrhage, diarrhea, vomiting, dyspepsia, anorexia, constipation, tooth disorder, dry mouth. Nervous — dizziness, anxiety, insomnia, somnolence, akathisia, agitation, extrapyramidal syndrome, hypertonia, cogwheel rigidity, paresthesia, personality disorder, psychosis, speech disorder. Respiratory — rhinitis. Skin and Appendages — furunculosis, sweating. Urogenital — dysmenorrhea, priapism. **DRUG ABUSE AND DEPENDENCE — *Controlled Substance Class:*** GEODON is not a controlled substance. **OVERDOSAGE** — In premarketing trials in over 5400 patients, accidental or intentional overdosage of GEODON was documented in 10 patients. All patients survived without sequelae. In the patient taking the largest confirmed amount (3240 mg), the only symptoms reported were minimal sedation, slurring of speech, and transitory hypertension (BP 200/95).

References: 1. Data on file. Pfizer Inc, New York, NY. **2.** Simpson GM, Glick ID, Weiden PJ, Romano SJ, Siu CO. Randomized, controlled, double-blind multicenter comparison of the efficacy and tolerability of ziprasidone and olanzapine in acutely ill inpatients with schizophrenia or schizoaffective disorder. *Am J Psychiatry*. 2004;161:1837-1847. **3.** Addington DEN, Pantelis C, Dineen M, Benattia I, Romano SJ. Efficacy and tolerability of ziprasidone versus risperidone in patients with acute exacerbation of schizophrenia or schizoaffective disorder: an 8-week, double-blind, multicenter trial. *J Clin Psychiatry*. 2004;65:1624-1633. **4.** Simpson GM, Weiden P, Pigott T, Murray S, Siu CO, Romano SJ. Six-month, blinded, multicenter continuation study of ziprasidone versus olanzapine in schizophrenia. *Am J Psychiatry*. 2005;162:1535-1538. **5.** Weiden PJ, Loebel A, Yang R, Lebovitz H. Course of weight & metabolic benefits 1 year after switching to ziprasidone. Presented at: American Psychiatric Association Annual Meeting; May 1-6, 2004; New York, NY.

Revised November 2006

DB Presidents Describe Troubled MH Systems

APA's Trustees hear reports from two district branch presidents that even before Katrina devastated Gulf Coast states, their mental health systems were severely underfunded and unable to meet the demand for psychiatric care.

BY KEN HAUSMAN

With last month's Board of Trustees meeting being held in New Orleans following the close of the Institute on Psychiatric Services, it was fitting that Board members received a report from the presidents of two local district branches (DBs)—those representing Louisiana and Mississippi—on issues they and their colleagues face in the post-Katrina environment.

Daphne Glindmeyer, M.D., of the Louisiana DB, said her organization is dealing with a greatly reduced membership roster and an attendant loss of income that has added to their struggles. Many members resigned after the state granted psychologists prescribing privileges, with some blaming the local DB and national APA for not doing enough to head it off, she noted. In 2003, the year before the prescribing bill passed, the DB had 464 members; by 2005, there were only 392. And then Katrina hit, further devastating the membership as psychiatrists moved to other states where they didn't have to cope "with a broken system" and a lack of health-system "infrastructure." Membership has recently edged up to 403.

Now the remaining psychiatrists face far more patients who are very sick, and waits for care are growing rapidly.

Further complicating the lives of Louisiana psychiatrists, she said, is the imminent application of a term-limits law in the legislature, which means there will be a major turnover, "and we don't know who our friends and foes are" and thus who to target in lobbying efforts.

Philip Scurria, M.D., president of the Mississippi DB, also described how Katrina devastated an already seriously underfunded and understaffed mental health system in his state. He noted that he is the only full-time psychiatrist in the Mississippi Delta region between Baton Rouge and Memphis. In many parts of the state waits of two to three months to see a psychiatrist are the norm, putting "a tremendous load on emergency rooms." In the storm-ravaged Gulf Coast area, the suffering is particularly dramatic, and while he expressed gratitude for the volunteers who provided mental health crisis intervention after the storm, he said there are far too few clinicians left there to treat people who will be "suffering with lifelong illnesses."

Incarcertaing mentally ill individuals is common in the state, he added, with the state hospital routinely having a three-week wait for beds to become available. "Some are just sent home to wait for a bed, even though they may have been declared dangerous to themselves or others," Scurria said.

Mississippi's clinician shortage is most severe for children needing psychiatric care. There are fewer than 20 child psychiatrists in the state, he pointed out, with 90 percent of them located in Jackson, the state's largest city and site of its only medical school.

The Trustees also heard from psychiatrist Anand Pandya, M.D., president of the National Alliance on Mental Illness (NAMI), who discussed the organization's new initiatives. One effort, NAMI Connections, is to have a three-year roll-out of a peer-support-group model to be available in every state and major metropolitan area. As is the case with Alcoholics Anonymous, people who participate in one of these support groups could find one in any state to which they traveled and understand the concept and terminology being used. He said that these programs were already operational in 12 states through funding from AstraZeneca.

NAMI is also focusing on lesbian, gay, bisexual, and transgender people with major mental illness, Pandya explained, including the difficulty some of these individuals have in getting a psychiatrist or mental health professional to treat them unless they agree to discuss their sexual orientation as a major part of therapy.

He also urged APA to add "consumer members" to its Academic Consortium, which lobbies Congress on research funding for mental illness research.

The Board took action on several issues at last month's meeting. Among them, the Trustees voted to

- **earmark $300,000 to be distributed through competitive grants to APA district branches and state association**. The Council on Member and District Branch Relations, which reviews requests for these grants, approved 27 grant requests ranging from $1,200 to $25,000.

please see ***Board*** *on page 12*

Credit: James Krajeski

NAMI President Anand Pandya, M.D., describes major initiatives the organization is undertaking, including programs focusing on gay, lesbian, bisexual, and transgender people with mental illness.

Credit: James Krajeski

Credit: James Krajeski

Daphne Glindmeyer, M.D, president of the Louisiana district branch, and Philip Scurria, M.D., president of the Mississippi district branch, gave vivid and often disturbing accounts of post-Katrina mental health care in their states and answered questions from APA Board members.

Depression

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tion on Psychiatry and Behavioral Science and CEO of Bailey Psychiatric Associates in League City, Texas, noted that there are only about 2,000 black psychiatrists in the United States.

Stigma surrounding mental illness and depression may be compounded in African Americans, he said, by social and cultural factors unique to the African-American experience, which include strongly held religious beliefs, distrust of the medical profession, and the legacy of racism and suffering. Bailey said that depression is not discussed openly in many black communities.

"Recognizing that depression exists in our communities is the first step" to recovery, he noted. But mood disorders such as depression are vastly underdiagnosed in African Americans, even though they often suffer from severe forms of the disorders.

He cited results from a study by David Williams, Ph.D., published in the March *Archives of General Psychiatry* showing that a higher proportion of African Americans (56.5 percent) with depression rated their depression as severe or very severe than did Caucasians (38.6 percent).

He echoed Stewart's concern that many psychiatrists may be inadequately prepared to deal with cultural issues impacting African-American patients. He noted as well that African Americans may metabolize psychotropic medications at different rates than do people of other races, but that some psychiatrists may not take this into account.

Bailey also pointed out that only about half of African Americans have health insurance plans that cover mental health treatment and that they are more likely to be enrolled in so-called "low-income" insurance plans such as Medicaid, which require high copays for mental health services.

Mental health advocate and author of *Black Pain: It Just Looks Like We're Not Hurting*, Terri Williams, L.C.S.W., noted that black women have a "supposed birthright to strength—we're supposed to be strong, nurturers, caretakers, and healers of other people."

Williams commented on the fact that the signs of depression are often unacknowledged by black women experiencing them. Black women suffer every day, she said, "because we really don't know what our pain looks like. . .or what it feels like."

She spoke from experience. As someone who struggled with depression for decades, she described the nadir of her depression: "I could barely get out of bed. I would lie there in the fetal position and cry," she noted.

Williams said that she is doing well in treatment. ■

BMS to Pay Huge Fine For Marketing Practices

A major drug company agrees to pay more than a half-billion dollars to settle lawsuits accusing it of inflating drug prices and marketing off-label use of its antipsychotic drug.

BY JUN YAN

Bristol-Myers Squibb (BMS) and its subsidiary, Apothecon Inc., have agreed to settle a number of civil cases with the federal government for a total of $515 million, the U.S. Department of Justice announced in September.

The cases alleged that BMS and Apothecon engaged in illegal marketing and pricing practices to promote the sales of BMS drugs as well as illegal promotion of off-label use of aripiprazole (Abilify).

The civil settlement covers cases brought since 2005, in which the government charged that BMS and Apothecon illegally gave kickbacks and incentives to physicians and other health providers for purchasing BMS products in the 1990s and early 2000s.

The "illegal remuneration," according to a press release from the Department of Justice, included fees and expenses paid to physicians and other health care providers through consulting arrangements, advisory boards, and travel to luxurious resorts and in the forms of "prebates," market-share payments, and free goods. BMS and Apothecon inflated drug prices and overcharged federal health care payers "for a wide assortment of oncology and generic drug products" to give higher profit margins to the care providers, the government claimed.

The government also charged that the sales force of BMS illegally promoted its atypical antipsychotic drug Abilify for pediatric use and treatment of dementia-related psychosis from 2002 through 2005. Abilify had not been approved by the Food and Drug Administration for use in children until earlier this month.

In addition, the government alleged that BMS falsely reported the lowest price for its antidepressant drug nefazodone (Serzone) to Medicaid programs and thus violated the Medicaid Drug Rebate Statute, which entitles state Medicaid programs to the lowest drug prices set for commercial buyers. (BMS stopped manufacturing Serzone in 2004; nefazodone remains available in generic form.)

The civil settlement to resolve the charges among BMS, the Department of Justice, and the U.S. Attorney's Office for the District of Massachusetts amounted to $499 million plus $16 million in interest. As part of the settlement, BMS admitted no wrongdoing, but entered into a corporate integrity agreement with the Department of Health and Human Services to report its drug prices accurately for Medicare and other federal programs.

There are no criminal charges against BMS, according to the company.

The Department of Justice press release is posted at <www.usdoj.gov/opa/pr/2007/September/07_civ_782.html>. A BMS press release is posted at <newsroom.bms.com/index.php?s=press_releases&item=305>. ■

Board

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• **add a link on APA's Web site to a site that provides extensive information to help physicians who have been sued for malpractice.** The link is to the Physician Litigation Stress Resource Center, which was established by Maine psychiatrist Sara Charles, M.D., after she was the defendant in a malpractice suit filed by a patient in the 1980s. (Charles wrote a book about her experience titled *The Defendant: A Psychiatrist on Trial for Medical Malpractice.*)

• **undo the merger of the Board's secretary and treasurer positions.** For many years the positions were separate, but APA members voted in 2003, on a recommendation from the Board, for a bylaws change that combined them into one. The merger of the positions took place in 2005. It turns out, however, that the workload on the secretary side was far more than expected as it now includes reviews of potential conflicts of interests for all those suggested to participate in the development of *DSM-V.*

• **send a delegation of APA leaders to Puerto Rico to discuss ways to build a district branch infrastructure there and increase membership.** The Puerto Rico Psychiatric Society, part of Area 5, has no office or executive director and has suffered a substantial drop in its membership over the last several years.

• **create a corresponding committee to deal with mental health issues related to violence against children.** The committee's charge is to "remain abreast of developing knowledge in this area, facilitate and coordinate efforts of other relevant APA components, and develop proposals for APA educational, research, and advocacy projects." ■

PSYCHIATRIC PRACTICE & MANAGED CARE
APA OFFICE OF HEALTHCARE SYSTEMS AND FINANCING

How to Appeal Denials Of Medicare Claims

From time to time, we like to remind APA members that it's usually worth their time to appeal Medicare claim denials. Medicare has a clearly delineated five-level process for appealing fee-for-service claim denials. Often when physicians present documentation to support the denied claim, Medicare pays the claim, if not at the first level of appeal, then at the second or third. What follows is a description of the appeals process, which has changed slightly in the past year. The same process applies to Part A denials as well as to Part B denials. (Medicare is in the process of moving to a system that consolidates Parts A and B administratively. Eventually Medicare administrative contractors that cover multistate regions will fill the role previously served by each state's Medicare Part B carrier(s) and Medicare Part A fiscal intermediaries.)

Requesting Carrier Redetermination

Within 120 days after the issuance of a Medicare carrier decision that you feel is incorrect—this may be either a denial or downcoding of a claim—you may request a redetermination of the decision. You must send a written request to the Medicare carrier whose decision you are contesting. Information on how to do this should be included in the initial determination. Medicare now provides an official Medicare Redetermination Request Form (Form CMS-20027), which can be accessed online at <www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf> or can be obtained from APA's Office of Healthcare Systems and Financing by calling the Managed Care Help Line at (800) 343-4671. Be sure to include your NPI number on the request form even though there is no specific space for it; we suggest putting it on the line with your name. The form states that if you are submitting evidence to support the claim, you should attach it to the form. (Send photocopies of the documentation, and keep the originals for your files.) If you believe that a cover letter explaining the service you provided would also be helpful, include that as well.

Within 60 days of your request, you should receive a Medicare Redetermination Notice (MRN) stating the carrier's decision regarding the denial's reversal.

If the decision is negative, don't feel defeated at this first level of appeal. Remember that the redetermination is made by the same entity that denied your claim in the first place. Keep in mind that many carrier decisions are overturned at subsequent levels of appeal.

Next Step: Reconsideration by a QIC

The next level of appeal is to a Qualified Independent Contractor (QIC). The MRN should provide instructions on how to file this appeal. There are four QICs, one serving each of the four geographical regions into which the Centers for Medicaid and Medicare Services has divided the country for this purpose. The MRN will tell you which QIC serves your locale.

After you receive notice of the carrier's redetermination, you have 180 days to request reconsideration by a QIC. This request can be submitted to the appropriate QIC using a Medicare Reconsideration Request Form (Form CMS-20033), which is posted on the CMS Web site at <www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf>, but it is wise to send an accompanying letter that explains in detail why you disagree with the carrier's redetermination decision and essentially makes your case to have the redetermination reversed. You will also need to include any evidence or documentation that the redetermination notice stated was missing, as well as any other documentation you believe will help your case. The MRN you received with the denial of your redetermination will indicate where you should send the request to continue the appeals process.

The QIC should send you its decision within 60 days of receiving your request for reconsideration. If the decision is not favorable, it will contain detailed information on the next level of appeal, the Administrative Law Judge (ALJ) hearing. If the QIC is not able to make its decision in a timely manner, it will also inform you of your right to proceed to the ALJ level. However, there must currently be at least $110 at issue for the appeal to be eligible for an ALJ hearing. If there is less money involved, the appeal process ends at the QIC level. This limit may be adjusted every year, and the amount is published yearly in the *Federal Register*. It has stayed the same for several years now, but you can check with APA's Managed Care Help Line at (800) 343-4671 to find out the current limit.

The Administrative Law Judge (ALJ) Hearing

Within 60 days after you receive the notice of the QIC decision, if there is at least $110 in question, you can file a written request for an ALJ hearing following the instructions sent with that decision. There is a form that can be used to make this request as well, CMS-20034 A/B, which can be accessed at <www.cms.hhs.gov/cmsforms/downloads/cms20034ab.pdf>.

When filing for an ALJ hearing, two or more physicians may aggregate claims to meet the $110 requirement if they involve the delivery of similar or related services to the same beneficiary or if the claims involve common issues of law and fact with respect to services provided to two or more beneficiaries. The only other stipulation is that all of these claims must have been subject to a QIC decision within 60 days of the ALJ hearing request.

ALJ hearings are usually held via video-teleconference or telephone. You may request an in-person hearing if you can establish good cause as to why the other methods will not do. If you wish, you may ask the ALJ to make a decision without a hearing—just on the basis of the written record.

ALJs are expected to issue decisions within 90 days of receiving the hearing request for standard appeals. However, the requirement for an in-person hearing or the need for more evidence may delay a decision. As with the previous levels of appeal, the ALJ hearing decision is binding on all parties unless there are further appeals or revisions of the decision.

Further Appeals

There are two levels of appeal beyond the ALJ hearing: the Medicare Appeals Council Review and the Federal District Court hearing. The requirements for these appeals are complex and stringent, and you should consult with a health care lawyer or a practice consultant before considering going on to these levels of appeal. A full discussion of the Medicare fee-for-service appeals process is posted at <www.cms.hhs.gov/OrgMedFFSAppeals/>.

Please note that appeals do not apply to rejected claims, which are generally sent back to the provider because the form has been filled out incorrectly. Carriers should explain the reason for the rejection when they return the claims. Rejected claims should be redone and resubmitted. ■

Psychiatric Practice & Managed Care (PP&MC) provides news and updates on practice management issues to APA members. PP&MC is printed bimonthly in *Psychiatric News* and is posted in PDF format under "Psychiatric Practice" on APA's Web site.

Is Part D Still Presenting Problems for You and Your Patients?

APA's Office of Healthcare Systems and Financing (OHSF) has been very successful in helping APA members get their Medicare patients access to the psychiatric drugs they require. Since Part D prescription drug plans are supposed to provide access to all or substantially all antidepressants, antipsychotics, and anticonvulsants, if you are having trouble accessing any medications in these categories, please contact APA's Managed Care Help Line at (800) 343-4671 for assistance. OHSF has also been effective in ensuring that patients get access to necessary medications in other classes.

The only way that APA can successfully ask that Medicare make necessary systemic changes to Part D is if OHSF can provide the Centers for Medicare and Medicaid Services with data showing which parts of the program are not working. Please let OHSF know if you or your staff or facility is having problems by calling the Managed Care Help Line. ■

Don't Forget to Keep Your Opt-Out Status Current!

Based on calls that have been received by the Managed Care Help Line, APA has learned that Medicare carriers have started tracking physicians' opt-out status (as have secondary payers). If you do not maintain your opt-out status when your two-year opt-out period ends, you are presumed to be back in the Medicare program and cannot have private contracts with your patients. This is the case even though you are not enrolled as a Medicare provider.

If you let your opt-out status lapse, you could find that when you send in your new opt-out affidavit, the Medicare carrier will ask you to refund any fees you collected from Medicare beneficiaries under private contracts during the time between the end of your last opt-out period and the start of your new one. The Help Line has received only one call about the occurrence of such a situation, but now that carriers appear to be tracking physicians' status, other psychiatrists can expect to be impacted as well.

Also, over the years the Managed Care Help Line has received a number of calls about another opt-out issue. APA members who had submitted opt-out affidavits to Medicare but had never enrolled as Medicare providers have sometimes been told by Medicare carriers that they must enroll in Medicare before they can opt out of the program. This is not true. Ellen Jaffe. the Medicare specialist in APA's Office of Healthcare Systems and Financing, investigated this issue with the staff member who oversees the Medicare opt-out program at the Centers for Medicare and Medicaid Services. The Medicare carrier does need identifying information to enable it to enter the physician's opt-out status into its computer system, but the information called for on the affidavit provided on APA's Web site at <www.psych.org/members/practpsych/optoutaffidavit121201.pdf> is enough—especially now that the National Provider Identifier (NPI) is being used instead of the Medicare UPIN. Jaffe advises that no one should attempt to opt out of Medicare without an NPI.

Complete information about opting out of Medicare can be obtained online at <www.psych.org/members/practpsych/optingoutofmedicare112701.cfm> or by phone from the Managed Care Help Line at (800) 343-4671. ■

Patients' First Encounter Can Color Schizophrenia's Course

The typically rapid success of antipsychotic medication in resolving positive symptoms in first-episode patients can have a downside, causing patients and family members to believe the illness has abated and medication is no longer needed.

BY MARK MORAN

Credit: Ellen Dallager

The first episode of psychosis "represents a unique window of opportunity to start treatment and to start to do it right," Nina Schooler, Ph.D., tells an audience at APA's Institute on Psychiatric Services.

A patient's first episode of psychosis offers a unique opportunity for clinicians to impact the individual's entire lifetime course of schizophrenia, said Nina Schooler, Ph.D., at APA's Institute on Psychiatric Services last month in New Orleans.

Schooler said longitudinal data regarding the effect of first-episode treatment on long-term course of disease has been exceedingly difficult to come by, yet she asserted that there are ample clinical and scientific reasons for believing that the first episode is a crucial window of opportunity to get patients started on the right foot.

She is a professor of psychiatry at the State University of New York Downstate Medical Center.

Especially crucial, she said, is the need for patients and family members to understand the long-term nature of schizophrenia, and she outlined a staged strategy for transitioning first-episode patients from the hospital to community care and into maintenance treatment.

"It is a belief I hold very strongly, though the data have been hard to assemble, that the quality of experience the patient has in the first encounter with us is going to color the rest of [the patient's] experience with the disorder" and his or her prognosis, she said.

"When you are treating chronic patients, you are dealing with an entire history of experience with the disease," Schooler told psychiatrists at the institute. "So the first episode represents a unique window of opportunity to start treatment and to start to do it right."

How to Define First Episode?

But Schooler acknowledged that defining when a patient is experiencing the "first episode" of psychosis can be difficult, since many patients are likely to have had anomalous perceptual experiences for years and to have received any number of diagnoses before becoming acutely psychotic.

"If you work with first-episode patients, you often find when they come to the clinic that they have had a variety of diagnoses along the way," she said. "Some of these diagnoses are legitimate, and some represent a tendency I have seen over the years, a wish on the part of both patients and clinicians not to have schizophrenia and so to try treatment with other medications—antidepressants being the most common."

Retrospective case reports indicate that when a patient first comes to the attention of the mental health system, clinicians should not assume that the patient is experiencing the symptoms "de novo," that is, for the first time.

"We have found that if you ask how long they have been experiencing symptoms, at the time they first come to the clinic they will give you a shorter duration than they will when you inquire a year later after you build up a relationship of trust," Schooler said. "At that time, many patients will tell you, 'Oh, I've been hearing those voices since I was in junior high school.' But when you initially ask, they will tell you a much shorter duration."

For research purposes, Schooler described criteria for defining first-episode psychosis that she used in a report comparing first-episode treatment with risperidone and haloperidol published in the *American Journal of Psychiatry* in 2005.

In that study, patients were deemed to be in first episode if they had a diagno-

please see ***Schizophrenia*** *on page 22*

NARSAD Honors Breakthroughs In Mental Illness Research

NARSAD started awarding a prize for schizophrenia research 20 years ago. Since then other prizes have been added to recognize scientists whose creative thinking and hard work have advanced mental health research.

BY JOAN AREHART-TREICHEL

NARSAD is the world's leading mental health research charity. Since its inception 20 years ago, it has awarded more than 3,200 research grants totaling more than $219 million to scientists working in the United States and 26 other countries.

At its annual fundraising gala last month, NARSAD awarded annual prizes for achievement in mental health research. These awards went to the following scientists:

• **The Lieber Prize for Outstanding Achievement in Schizophrenia Research** was awarded to Eve Johnstone, M.D., a professor of psychiatry at the University of Edinburgh in Scotland. For more than three decades she has used advanced brain-imaging methods to elucidate structural and functional changes associated with schizophrenia. According to William Bunney Jr., M.D., chair of NARSAD's Lieber Prize Selection Committee, "She initiated the most replicated finding in the literature on psychosis—enlargement of the lateral ventricles in the brain."

• **The Falcone Prize for Outstanding Achievement in Mood Disorders Research** went to Helen Mayberg, M.D., a professor of psychiatry at Emory University. For more than 20 years she has used functional neuroimaging to examine neural mechanisms implicated in the onset of depression. She also hypothesized, on the basis of the information she had collected, that the anterior cingulate cortex was pivotal in regulating depressed mood and proceeded to stimulate this region electrically. Thus, deep brain stimulation for treatment-resistant depression was born. "A number of the most treatment-resistant patients who received this treatment have shown remarkable antidepressant

please see ***NARSAD*** *on facing page*

Credit: NARSAD/Charles Manley

NARSAD awarded its 2007 prizes for outstanding research achievements on October 19 in New York City. The winners are (from left) James Leckman, M.D., Yale University, Ruane Prize for Child and Adolescent Psychiatry; Helen Mayberg, M.D., Emory University, Falcone Prize for Mood Disorders Research; Eve Johnstone, M.D., Edinburgh University, Lieber Prize for Schizophrenia Research; Jeremy Hall, M.D., Ph.D., Edinburgh University, Sidney R. Baer Jr. Prize; and Huda Akil, Ph.D., University of Michigan, Goldman-Rakic Prize for Cognitive Neuroscience.

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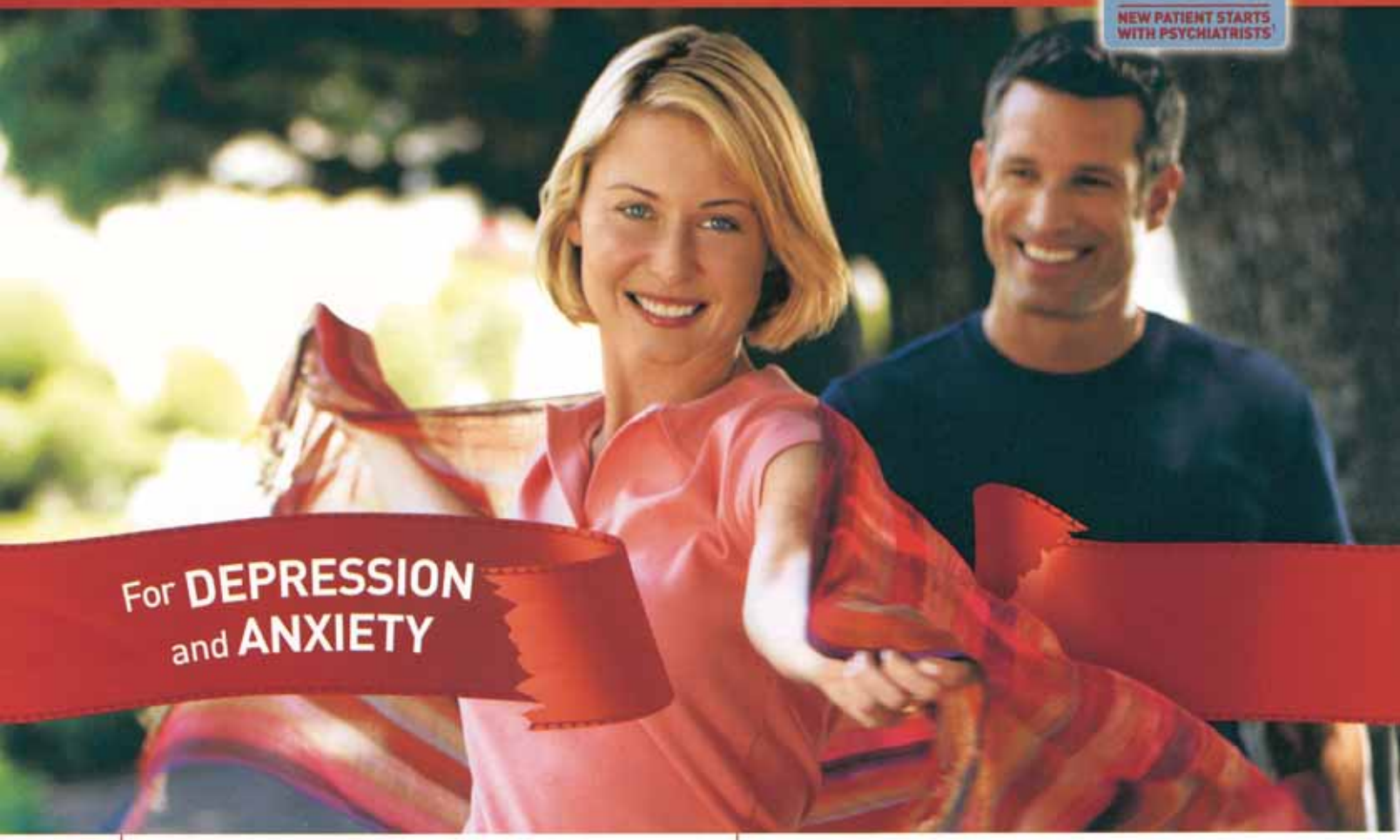

UP TO 90% of depressed patients present with symptoms of anxiety[2]

PROVEN EFFICACY for Major Depressive Disorder and Generalized Anxiety Disorder[3]

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IMPORTANT SAFETY INFORMATION - Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Antidepressants increased the risk of suicidality (suicidal thinking and behavior) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of antidepressants in children, adolescents or young adults must balance the risk to clinical need. Patients of all ages started on antidepressant therapy should be closely monitored and observed for clinical worsening, suicidality or unusual changes in behavior, especially at the beginning of therapy or at the time of dose changes. This risk may persist until significant remission occurs. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients.

Lexapro is contraindicated in patients taking monoamine oxidase inhibitors (MAOIs), pimozide (see DRUG INTERACTIONS – Pimozide and Celexa), or in patients with hypersensitivity to escitalopram oxalate. As with other SSRIs, caution is indicated in the coadministration of tricyclic antidepressants (TCAs) with Lexapro. As with other psychotropic drugs that interfere with serotonin reuptake, patients should be cautioned regarding the risk of bleeding associated with the concomitant use of Lexapro with NSAIDs, aspirin, or other drugs that affect coagulation. The most common adverse events with Lexapro versus placebo (approximately 5% or greater and approximately 2x placebo) were nausea, insomnia, ejaculation disorder, somnolence, increased sweating, fatigue, decreased libido, and anorgasmia.

References: 1. Verispan Weekly VONA Data (Retail Only). Twenty-four-week rolling average. September 2006. **2.** Sadock BJ, Sadock VA. *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry.* 9th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2003:552. **3.** LEXAPRO (package insert). St Louis, Mo: Forest Pharmaceuticals, Inc.; 2007.

Please see brief summary of prescribing information for LEXAPRO on following page.

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Brief Summary: For complete details, please see full prescribing information for Lexapro.

Suicidality and Antidepressant Drugs Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Lexapro or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients. (See WARNINGS: Clinical Worsening and Suicide Risk, PRECAUTIONS: Information for Patients, and PRECAUTIONS: Pediatric Use)

CONTRAINDICATIONS Concomitant use in patients taking monoamine oxidase inhibitors (MAOIs) is contraindicated (see **WARNINGS**). Concomitant use in patients taking pimozide is contraindicated (see **Drug Interactions – Pimozide and Celexa**). Lexapro is contraindicated in patients with a hypersensitivity to escitalopram or citalopram or any of the inactive ingredients in Lexapro. **WARNINGS WARNINGS-Clinical Worsening and Suicide Risk Clinical Worsening and Suicide Risk** Patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide. There has been a long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment. Pooled analyses of short-term placebo-controlled trials of antidepressant drugs (SSRIs and others) showed that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18-24) with major depressive disorder (MDD) and other psychiatric disorders. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction with antidepressants compared to placebo in adults aged 65 and older. The pooled analyses of placebo-controlled trials in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4400 patients. The pooled analyses of placebo-controlled trials in adults with MDD or other psychiatric disorders included a total of 295 short-term trials (median duration of 2 months) of 11 antidepressant drugs in over 77,000 patients. There was considerable variation in risk of suicidality among drugs, but a tendency toward an increase in the younger patients for almost all drugs studied. There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD. The risk differences (drug vs. placebo), however, were relatively stable within age strata and across indications. These risk differences (drug-placebo difference in the number of cases of suicidality per 1000 patients treated) are provided in **Table 1. TABLE 1: Age Range and Drug-Placebo Difference in Number of Cases of Suicidality per 1000 Patients Treated:** Drug-Related Increases; <18 (14 additional cases); 18-24 (5 additional cases); Drug-Related Decreases; 25-64 (1 fewer case); ≥65 (6 fewer cases). No suicides occurred in any of the pediatric trials. There were suicides in the adult trials, but the number was not sufficient to reach any conclusion about drug effect on suicide. It is unknown whether the suicidality risk extends to longer-term use, i.e., beyond several months. However, there is substantial evidence from placebo-controlled maintenance trials in adults with depression that the use of antidepressants can delay the recurrence of depression. **All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.** The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality. Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms. If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms (see PRECAUTIONS and DOSAGE AND ADMINISTRATION—Discontinuation of Treatment with Lexapro, for a description of the risks of discontinuation of Lexapro). **Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers. Such monitoring should include daily observation by families and caregivers.** Prescriptions for Lexapro should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. **Screening Patients for Bipolar Disorder:** A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. It should be noted that Lexapro is not approved for use in treating bipolar depression. **Potential for Interaction with Monoamine Oxidase Inhibitors In patients receiving serotonin reuptake inhibitor drugs in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued SSRI treatment and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Furthermore, limited animal data on the effects of combined use of SSRIs and MAOIs suggest that these drugs may act synergistically to elevate blood pressure and evoke behavioral excitation. Therefore, it is recommended that Lexapro should not be used in combination with an MAOI, or within 14 days of discontinuing treatment with an MAOI. Similarly, at least 14 days should be allowed after stopping Lexapro before starting an MAOI. Serotonin syndrome has been reported in two patients who were concomitantly receiving linezolid, an antibiotic which is a reversible non-selective MAOI.** ***Serotonin Syndrome:*** The development of a potentially life-threatening serotonin syndrome may occur with SNRIs and SSRIs, including Lexapro treatment, particularly with concomitant use of serotonergic drugs (including triptans) and with drugs which impair metabolism of serotonin (including MAOIs). Serotonin syndrome symptoms may include mental status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g., tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (e.g., hyperreflexia, incoordination) and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). The concomitant use of Lexapro with MAOIs intended to treat depression is contraindicated (see **CONTRAINDICATIONS** and **WARNINGS - Potential for Interaction with Monoamine Oxidase Inhibitors.**) If concomitant treatment of Lexapro with a 5-hydroxytryptamine receptor agonist (triptan) is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see **PRECAUTIONS - Drug Interactions**).The concomitant use of Lexapro with serotonin precursors (such as tryptophan) is not recommended (see **PRECAUTIONS - Drug Interactions**). **PRECAUTIONS General** Discontinuation of Treatment with Lexapro During marketing of Lexapro and other SSRIs and SNRIs (serotonin and norepinephrine reuptake inhibitors), there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia, and hypomania. While these events are generally self-limiting, there have been reports of serious discontinuation symptoms. Patients should be monitored for these symptoms when discontinuing treatment with Lexapro. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate (see **DOSAGE AND ADMINISTRATION**). Abnormal Bleeding Published case reports have documented the occurrence of bleeding episodes in patients treated with psychotropic drugs that interfere with serotonin reuptake. Subsequent epidemiological studies, both of the case-control and cohort design, have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding. In two studies, concurrent use of a nonsteroidal anti-inflammatory drug (NSAID) or aspirin potentiated the risk of bleeding (see **Drug Interactions**). Although these studies focused on upper gastrointestinal bleeding, there is reason to believe that bleeding at other sites may be similarly potentiated. Patients should be cautioned regarding the risk of bleeding associated with the concomitant use of Lexapro with NSAIDs, aspirin, or other drugs that affect coagulation. Hyponatremia Cases of hyponatremia and SIADH (syndrome of inappropriate antidiuretic hormone secretion) have been reported in association with Lexapro treatment. All patients with these events have recovered with discontinuation of escitalopram and/or medical intervention. Hyponatremia and SIADH have also been reported in association with other marketed drugs effective in the treatment of major depressive disorder. Activation of Mania/Hypomania In placebo-controlled trials of Lexapro in major depressive disorder, activation of mania/hypomania was reported in one (0.1%) of 715 patients treated with Lexapro and in none of the 592 patients treated with placebo. One additional case of hypomania has been reported in association with Lexapro treatment. Activation of mania/hypomania has also been reported in a small proportion of patients with major affective disorders treated with racemic citalopram and other marketed drugs effective in the treatment of major depressive disorder. As with all drugs effective in the treatment of major depressive disorder, Lexapro should be used cautiously in patients with a history of mania. Seizures Although anticonvulsant effects of racemic citalopram have been observed in animal studies, Lexapro has not been systematically evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the product's premarketing testing. In clinical trials of Lexapro, cases of convulsion have been reported in association with Lexapro treatment. Like other drugs effective in the treatment of major depressive disorder, Lexapro should be introduced with care in patients with a history of seizure disorder. Interference with Cognitive and Motor Performance In a study in normal volunteers, Lexapro 10 mg/day did not produce impairment of intellectual function or psychomotor performance. Because any psychoactive drug may impair judgment, thinking, or motor skills, however, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro therapy does not affect their ability to engage in such activities. Use in Patients with Concomitant Illness Clinical experience with Lexapro in patients with certain concomitant systemic illnesses is limited. Caution is advisable in using Lexapro in patients with diseases or conditions that produce altered metabolism or hemodynamic responses. Lexapro has not been systematically evaluated in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were generally excluded from clinical studies during the product's premarketing testing. In subjects with hepatic impairment, clearance of racemic citalopram was decreased and plasma concentrations were increased. The recommended dose of Lexapro in hepatically impaired patients is 10 mg/day (see **DOSAGE AND ADMINISTRATION**). Because escitalopram is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. Until adequate numbers of patients with severe renal impairment have been evaluated during chronic treatment with Lexapro, however, it should be used with caution in such patients (see **DOSAGE AND ADMINISTRATION**). **Information for Patients** Physicians are advised to discuss the following issues with patients for whom they prescribe Lexapro. Patients should be cautioned about the risk of serotonin syndrome with the concomitant use of Lexapro and triptans, tramadol or other serotonergic agents. In a study in normal volunteers, Lexapro 10 mg/day did not impair psychomotor performance. The effect of Lexapro on psychomotor coordination, judgment, or thinking has not been systematically examined in controlled studies. Because psychoactive drugs may impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro therapy does not affect their ability to engage in such activities. Patients should be told that, although Lexapro has not been shown in experiments with normal subjects to increase the mental and motor skill impairments caused by alcohol, the concomitant use of Lexapro and alcohol in depressed patients is not advised. Patients should be made aware that escitalopram is the active isomer of Celexa (citalopram hydrobromide) and that the two medications should not be taken concomitantly. Patients should be advised to inform their physician if they are taking, or plan to take, any prescription or over-the-counter drugs, as there is a potential for interactions. Patients should be cautioned about the concomitant use of Lexapro and NSAIDs, aspirin, or other drugs that affect coagulation since the combined use of psychotropic drugs that interfere with serotonin reuptake and these agents has been associated with an increased risk of bleeding. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. Patients should be advised to notify their physician if they are breastfeeding an infant. While patients may notice improvement with Lexapro therapy in 1 to 4 weeks, they should be advised to continue therapy as directed. Prescribers or other health professionals should inform patients, their families, and their caregivers about the benefits and risks associated with treatment with Lexapro and should counsel them in its appropriate use. A patient Medication Guide about "Antidepressant Medicines, Depression and other Serious Mental Illness, and Suicidal Thoughts or Actions" is available for Lexapro. The prescriber or health professional should instruct patients, their families, and their caregivers to read the Medication Guide and should assist them in understanding its contents. Patients should be given the opportunity to discuss the contents of the Medication Guide and to obtain answers to any questions they may have. Patients should be advised of the following issues and asked to alert their prescriber if these occur while taking Lexapro. **Clinical Worsening and Suicide Risk:** Patients, their families, and their caregivers should be encouraged to be alert to the emergence of anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, mania, other unusual changes in behavior, worsening of depression, and suicidal ideation, especially early during anti-depressant treatment and when the dose is adjusted up or down. Families and caregivers of patients should be advised to look for the emergence of such symptoms on a day-to-day basis, since changes may be abrupt. Such symptoms should be reported to the patient's prescriber or health professional, especially if they are severe, abrupt in onset, or were not part of the patient's presenting symptoms. Symptoms such as these may be associated with an increased risk for suicidal thinking and behavior and indicate a need for very close monitoring and possibly changes in the medication. **Laboratory Tests** There are no specific laboratory tests recommended. **Concomitant Administration with Racemic Citalopram** Citalopram - Since escitalopram is the active isomer of racemic citalopram (Celexa), the two agents should not be coadministered. **Drug Interactions Serotonergic Drugs:** Based on the mechanism of action of SNRIs and SSRIs including Lexapro, and the potential for serotonin syndrome, caution is advised when Lexapro is coadministered with other drugs that may affect the serotonergic neurotransmitter systems, such as triptans, linezolid (an antibiotic which is a reversible non-selective MAOI), lithium, tramadol, or St. John's Wort (see **WARNINGS-Serotonin Syndrome**). The concomitant use of Lexapro with other SSRIs, SNRIs or tryptophan is not recommended (see **PRECAUTIONS - Drug Interactions**). **Triptans:** There have been rare postmarketing reports of serotonin syndrome with use of an SSRI and a triptan. If concomitant treatment of Lexapro with a triptan is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see **WARNINGS - Serotonin Syndrome**). CNS Drugs - Given the primary CNS effects of escitalopram, caution should be used when it is taken in combination with other centrally acting drugs. Alcohol - Although Lexapro did not potentiate the cognitive and motor effects of alcohol in a clinical trial, as with other psychotropic medications, the use of alcohol by patients taking Lexapro is not recommended. Monoamine Oxidase Inhibitors (MAOIs) - See **CONTRAINDICATIONS** and **WARNINGS**. **Drugs That Interfere With Hemostasis (NSAIDs, Aspirin, Warfarin, etc.)** Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of the case-control and cohort design that have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding have also shown that concurrent use of an NSAID or aspirin potentiated the risk of bleeding. Thus, patients should be cautioned about the use of such drugs concurrently with Lexapro. Cimetidine - In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of 400 mg/day cimetidine for 8 days resulted in an increase in citalopram AUC and C_{max} of 43% and 39%, respectively. The clinical significance of these findings is unknown. Digoxin - In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of citalopram and digoxin (single dose of 1 mg) did not significantly affect the pharmacokinetics of either citalopram or digoxin. Lithium - Coadministration of racemic citalopram (40 mg/day for 10 days) and lithium (30 mmol/day for 5 days) had no significant effect on the pharmacokinetics of citalopram or lithium. Nevertheless, plasma lithium levels should be monitored with appropriate adjustment to the lithium dose in accordance with standard clinical practice. Because lithium may enhance the serotonergic effects of escitalopram, caution should be exercised when Lexapro and lithium are coadministered. Pimozide and Celexa - In a controlled study, a single dose of pimozide 2 mg co-administered with racemic citalopram 40 mg given once daily for 11 days was associated with a mean increase in QTc values of approximately 10 msec compared to pimozide given alone. Racemic citalopram did not alter the mean AUC or C_{max} of pimozide. The mechanism of this pharmacodynamic interaction is not known. Sumatriptan - There have been rare postmarketing reports describing patients with weakness, hyperreflexia, and incoordination following the use of an SSRI and sumatriptan. If concomitant treatment with sumatriptan and an SSRI (e.g., fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram) is clinically warranted, appropriate observation of the patient is advised. Theophylline - Combined administration of racemic citalopram (40 mg/day for 21 days) and the CYP1A2 substrate theophylline (single dose of 300 mg) did not affect the pharmacokinetics of theophylline. The effect of theophylline on the pharmacokinetics of citalopram was not evaluated. Warfarin - Administration of 40 mg/day racemic citalopram for 21 days did not affect the pharmacokinetics of warfarin, a CYP3A4 substrate. Prothrombin time was increased by 5%, the clinical significance of which is unknown. Carbamazepine - Combined administration of racemic citalopram (40 mg/day for 14 days) and carbamazepine (titrated to 400 mg/day for 35 days) did not significantly affect the pharmacokinetics of carbamazepine, a CYP3A4 substrate. Although trough citalopram plasma levels were unaffected, given the enzyme-inducing properties of carbamazepine, the possibility that carbamazepine might increase the clearance of escitalopram should be considered if the two drugs are coadministered. Triazolam - Combined administration of racemic citalopram (titrated to 40 mg/day for 28 days) and the CYP3A4 substrate triazolam (single dose of 0.25 mg) did not significantly affect the pharmacokinetics of either citalopram or triazolam. Ketoconazole - Combined administration of racemic citalopram (40 mg) and ketoconazole (200 mg), a potent CYP3A4 inhibitor, decreased the C_{max} and AUC of ketoconazole by 21% and 10%, respectively, and did not significantly affect the pharmacokinetics of citalopram. Ritonavir - Combined administration of a single dose of ritonavir (600 mg), both a CYP3A4 substrate and a potent inhibitor of CYP3A4, and escitalopram (20 mg) did not affect the pharmacokinetics of either ritonavir or escitalopram. CYP3A4 and -2C19 Inhibitors - *In vitro* studies indicated that CYP3A4 and -2C19 are the primary enzymes involved in the metabolism of escitalopram. However, coadministration of escitalopram (20 mg) and ritonavir (600 mg), a potent inhibitor of CYP3A4, did not significantly affect the pharmacokinetics of escitalopram. Because escitalopram is metabolized by multiple enzyme systems, inhibition of a single enzyme may not appreciably decrease escitalopram clearance. Drugs Metabolized by Cytochrome P4502D6 - *In vitro* studies did not reveal an inhibitory effect of escitalopram on CYP2D6. In addition, steady state levels of racemic citalopram were not significantly different in poor metabolizers and extensive CYP2D6 metabolizers after multiple-dose administration of citalopram, suggesting that coadministration, with escitalopram, of a drug that inhibits CYP2D6, is unlikely to have clinically significant effects on escitalopram metabolism. However, there are limited *in vivo* data suggesting a modest CYP2D6 inhibitory effect for escitalopram, i.e., coadministration of escitalopram (20 mg/day for 21 days) with the tricyclic antidepressant desipramine (single dose of 50 mg), a substrate for CYP2D6, resulted in a 40% increase in C_{max} and a 100% increase in AUC of desipramine. The clinical significance of this finding is unknown. Nevertheless, caution is indicated in the coadministration of escitalopram and drugs metabolized by CYP2D6. Metoprolol - Administration of 20 mg/day Lexapro for 21 days in healthy volunteers resulted in a 50% increase in C_{max} and 82% increase in AUC of the beta-adrenergic blocker metoprolol (given in a single dose of 100 mg). Increased metoprolol plasma levels have been associated with decreased cardioselectivity. Coadministration of Lexapro and metoprolol had no clinically significant effects on blood pressure or heart rate. Electroconvulsive Therapy (ECT) - There are no clinical studies of the combined use of ECT and escitalopram. **Carcinogenesis, Mutagenesis, Impairment of Fertility** Carcinogenesis Racemic citalopram was administered in the diet to NMRI/BOM strain mice and COBS WI strain rats for 18 and 24 months, respectively. There was no evidence for carcinogenicity of racemic citalopram in mice receiving up to 240 mg/kg/day. There was an increased incidence of small intestine carcinoma in rats receiving 8 or 24 mg/kg/day racemic citalopram. A no-effect dose for this finding was not established. The relevance of these findings to humans is unknown. Mutagenesis Racemic citalopram was mutagenic in the *in vitro* bacterial reverse mutation assay (Ames test) in 2 of 5 bacterial strains (Salmonella TA98 and TA1537) in the absence of metabolic activation. It was clastogenic in the *in vitro* Chinese hamster lung cell assay for chromosomal aberrations in the presence and absence of metabolic activation. Racemic citalopram was not mutagenic in the *in vitro* mammalian forward gene mutation assay (HPRT) in mouse lymphoma cells or in a coupled *in vitro*/*in vivo* unscheduled DNA synthesis (UDS) assay in rat liver. It was not clastogenic in the *in vitro* chromosomal aberration assay in human lymphocytes or in two *in vivo* mouse micronucleus assays. Impairment of Fertility When racemic citalopram was administered orally to 16 male and 24 female rats prior to and throughout mating and gestation at doses of 32, 48, and 72 mg/kg/day, mating was decreased at all doses, and fertility was decreased at doses ≥ 32 mg/kg/day. Gestation duration was increased at 48 mg/kg/day. **Pregnancy** Pregnancy Category C In a rat embryo/fetal development study, oral administration of escitalopram (56, 112, or 150 mg/kg/day) to pregnant animals during the period of organogenesis resulted in decreased fetal body weight and associated delays in ossification at the two higher doses (approximately ≥ 56 times the maximum recommended human dose [MRHD] of 20 mg/day on a body surface area [mg/m^2] basis). Maternal toxicity (clinical signs and decreased body weight gain and food consumption), mild at 56 mg/kg/day, was present at all dose levels. The developmental no-effect dose of 56 mg/kg/day is approximately 28 times the MRHD on a mg/m^2 basis. No teratogenicity was observed at any of the doses tested (as high as 75 times the MRHD on a mg/m^2 basis). When female rats were treated with escitalopram (6, 12, 24, or 48 mg/kg/day) during pregnancy and through weaning, slightly increased offspring mortality and growth retardation were noted at 48 mg/kg/day which is approximately 24 times the MRHD on a mg/m^2 basis. Slight maternal toxicity (clinical signs and decreased body weight gain and food consumption) was seen at this dose. Slightly increased offspring mortality was seen at 24 mg/kg/day. The no-effect dose was 12 mg/kg/day which is approximately 6 times the MRHD on a mg/m^2 basis. In animal reproduction studies, racemic citalopram has been shown to have adverse effects on embryo/fetal and postnatal development, including teratogenic effects, when administered at doses greater than human therapeutic doses. In two rat embryo/fetal development studies, oral administration of racemic citalopram (32, 56, or 112 mg/kg/day) to pregnant animals during the period of organogenesis resulted in decreased embryo/fetal growth and survival and an increased incidence of fetal abnormalities (including cardiovascular and skeletal defects) at the high dose. This dose was also associated with maternal toxicity (clinical signs, decreased body weight gain). The developmental no-effect dose was 56 mg/kg/day. In a rabbit study, no adverse effects on embryo/fetal development were observed at doses of racemic citalopram of up to 16 mg/kg/day. Thus, teratogenic effects of racemic citalopram were observed at a maternally toxic dose in the rat and were not observed in the rabbit. When female rats were treated with racemic citalopram (4.8, 12.8, or 32 mg/kg/day) from late gestation through weaning, increased offspring mortality during the first 4 days after birth and persistent offspring growth retardation were observed at the highest dose. The no-effect dose was 12.8 mg/kg/day. Similar effects on offspring mortality and growth were seen when dams were treated throughout gestation and early lactation at doses ≥ 24 mg/kg/day. A no-effect dose was not determined in that study. There are no adequate and well-controlled studies in pregnant women; therefore, escitalopram should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Pregnancy-Nonteratogenic Effects** Neonates exposed to Lexapro and other SSRIs or SNRIs, late in the third trimester, have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome (see **WARNINGS**). Infants exposed to SSRIs in late pregnancy may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN). PPHN occurs in 1–2 per 1000 live births in the general population and is associated with substantial neonatal morbidity and mortality. In a retrospective, case-control study of 377 women whose infants were born with PPHN and 836 women whose infants were born healthy, the risk for developing PPHN was approximately six-fold higher for infants exposed to SSRIs after the 20th week of gestation compared to infants who had not been exposed to antidepressants during pregnancy. There is currently no corroborative evidence regarding the risk for PPHN following exposure to SSRIs in pregnancy; this is the first study that has investigated the potential risk. The study did not include enough cases with exposure to individual SSRIs to determine if all SSRIs posed similar levels of PPHN risk. When treating a pregnant woman with Lexapro during the third trimester, the physician should carefully consider both the potential risks and benefits of treatment (see **DOSAGE AND ADMINISTRATION**). Physicians should note that in a prospective longitudinal study of 201 women with a history of major depression who were euthymic at the beginning of pregnancy, women who discontinued antidepressant medication during pregnancy were more likely to experience a relapse of major depression than women who continued antidepressant medication. **Labor and Delivery** The effect of Lexapro on labor and delivery in humans is unknown. **Nursing Mothers** Racemic citalopram, like many other drugs, is excreted in human breast milk. There have been two reports of infants experiencing excessive somnolence, decreased feeding, and weight loss in association with breastfeeding from a citalopram-treated mother; in one case, the infant was reported to recover completely upon discontinuation of citalopram by its mother and, in the second case, no follow-up information was available. The decision whether to continue or discontinue either nursing or Lexapro therapy should take into account the risks of citalopram exposure for the infant and the benefits of Lexapro treatment for the mother. **Pediatric Use** Safety and effectiveness in the pediatric population have not been established (see **BOX WARNING** and **WARNINGS—Clinical Worsening and Suicide Risk**). One placebo-controlled trial in 264 pediatric patients with MDD has been conducted with Lexapro, and the data were not sufficient to support a claim for use in pediatric patients. Anyone considering the use of Lexapro in a child or adolescent must balance the potential risks with the clinical need. **Geriatric Use** Approximately 6% of the 1144 patients receiving escitalopram in controlled trials of Lexapro in major depressive disorder and GAD were 60 years of age or older; elderly patients in these trials received daily doses of Lexapro between 10 and 20 mg. The number of elderly patients in these trials was insufficient to adequately assess for possible differential efficacy and safety measures on the basis of age. Nevertheless, greater sensitivity of some elderly individuals to effects of Lexapro cannot be ruled out. In two pharmacokinetic studies, escitalopram half-life was increased by approximately 50% in elderly subjects as compared to young subjects and C_{max} was unchanged (see **CLINICAL PHARMACOLOGY**). 10 mg/day is the recommended dose for elderly patients (see **DOSAGE AND ADMINISTRATION**). Of 4422 patients in clinical studies of racemic citalopram, 1357 were 60 and over, 1034 were 65 and over, and 457 were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but again, greater sensitivity of some elderly individuals cannot be ruled out. **ADVERSE REACTIONS** Adverse event information for Lexapro was collected from 715 patients with major depressive disorder who were exposed to escitalopram and from 592 patients who were exposed to placebo in double-blind, placebo-controlled trials. An additional 284 patients with major depressive disorder were newly exposed to escitalopram in open-label trials. The adverse event information for Lexapro in patients with GAD was collected from 429 patients exposed to escitalopram and from 427 patients exposed to placebo in double-blind, placebo-controlled trials. Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tables and tabulations that follow, standard World Health Organization (WHO) terminology has been used to classify reported adverse events. The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. **Adverse Events Associated with Discontinuation of Treatment Major Depressive Disorder** Among the 715 depressed patients who received Lexapro in placebo-controlled trials, 6% discontinued treatment due to an adverse event, as compared to 2% of 592 patients receiving placebo. In two fixed-dose studies, the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro was not significantly different from the rate of discontinuation for adverse events in patients receiving placebo. The rate of discontinuation for adverse events in patients assigned to a fixed dose of 20 mg/day Lexapro was 10%, which was significantly different from the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro (4%) and placebo (3%). Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice that of placebo, were nausea (2%) and ejaculation disorder (2% of male patients). **Generalized Anxiety Disorder** Among the 429 GAD patients who received Lexapro 10-20 mg/day in placebo-controlled trials, 8% discontinued treatment due to an adverse event, as compared to 4% of 427 patients receiving placebo. Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice the placebo rate, were nausea (2%), insomnia (1%), and fatigue (1%). **Incidence of Adverse Events in Placebo-Controlled Clinical Trials Major Depressive Disorder Table 2** enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred among 715 depressed patients who received Lexapro at doses ranging from 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The prescriber should be aware that these figures can not be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse event incidence rate in the population studied. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were insomnia, ejaculation disorder (primarily ejaculatory delay), nausea, sweating increased, fatigue, and somnolence (see **TABLE 2**). **TABLE 2: Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Major Depressive Disorder* (Lexapro (N=715) and Placebo (N=592)): Autonomic Nervous System Disorders:** Dry Mouth (6% and 5%); Sweating Increased (5% and 2%). **Central & Peripheral Nervous System Disorders:** Dizziness (5% and 3%). **Gastrointestinal Disorders:** Nausea (15% and 7%); Diarrhea (8% and 5%); Constipation (3% and 1%); Indigestion (3% and 1%); Abdominal Pain (2% and 1%). **General:** Influenza-like Symptoms (5% and 4%); Fatigue (5% and 2%). **Psychiatric Disorders:** Insomnia (9% and 4%); Somnolence (6% and 2%); Appetite Decreased (3% and 1 %); Libido Decreased (3% and 1%). **Respiratory System Disorders:** Rhinitis (5% and 4%); Sinusitis (3% and 2%). **Urogenital:** Ejaculation Disorder[1,2] (9% and <1%); Impotence[2]

Epilepsy Drug Shows Efficacy In Treating Alcohol Dependence

Topiramate combined with a 15-minute, weekly behavioral intervention significantly reduced the number of heavy-drinking days in patients with alcohol-dependence disorder.

BY JUN YAN

Topiramate (Topamax), a drug approved for epilepsy and migraine, has shown promise in treating alcohol dependence in a randomized, double-blind study published in the October 10 *Journal of the American Medical Association (JAMA)*.

Adult patients who met *DSM-IV* criteria for alcohol dependence were enrolled in the study; those with psychiatric comorbidities (except alcohol, nicotine, or caffeine dependence) or recent substance abuse history were excluded. Half of the participants received topiramate and half received placebo for 14 weeks. All participants received a weekly brief behavioral treatment, delivered in about 15 minutes by trained personnel. The intervention provided motivational support and tools for adhering to medication treatment. A few participants attended Alcoholics Anonymous meetings during the study.

At the end of week 14, self-reported heavy-drinking days dropped from about 82 percent to 44 percent in the topiramate group and from 82 percent to 52 percent in the placebo group. The reduction was significantly higher in the topiramate group than in the placebo group, regardless of whether dropout patients were included in the calculation. The statistical significance between the two groups was achieved at week 4 and persisted through the end of week 14.

The self-reported drinking reduction was corroborated by the participants' plasma γ-glutamyltransferase, a liver enzyme indicating recent drinking, which also showed statistically significant difference between the topiramate and placebo groups. The rates of achieving at least 28 days of no heavy drinking or continuous abstinence were also statistically significantly higher in the topiramate group.

The dosage of topiramate tested in this study was 50 mg/day to 300 mg/day titrated over a six-week period. The mechanism of topiramate's effect may involve a range of activities on the GABA and glutamate receptors, the authors suggested.

Study participants in the topiramate group experienced more adverse effects than did the placebo group. The most commonly reported side effects that were significantly different between the treatment groups included tingling or numbing sensation in the skin (50.8 percent in the topiramate group versus 10.6 percent in the placebo group), change in taste (23 percent versus 4.8 percent), loss of appetite (19.7 percent versus 6.9 percent), and difficulty concentrating or paying attention (14.8 percent versus 3.2 percent).

Of note, 67 participants dropped out of the topiramate group before study completion; 34 did so because of adverse events. In the placebo group, 41 dropped out, including six because of adverse events. The authors recommended a slower titration over eight weeks, an approach that, in a study published in the May 17, 2003, *The Lancet*, achieved a participant retention rate similar to placebo.

The study was funded by Ortho-McNeil Janssen, a subsidiary of Johnson and Johnson. Ortho-McNeil Neurologics, also under Johnson and Johnson, manufactures topiramate.

"Our study shows that topiramate helped patients with alcohol dependence get better even during times of heavy drinking," Bankole Johnson, M.D., Ph.D., chair of the Department of Psychiatric Medicine at the University of Virginia and the lead author of the study, told *Psychiatric News*. "And it shows that a brief, simple, 15-minute behavioral intervention can be effective. It is easy to provide this intervention in the primary care setting by doctors or nurses, which will increase patients' access to the treatment they need for alcohol dependence." Johnson is a member of the APA Council on Addiction Psychiatry.

The brief intervention manual used in the study can be obtained from Johnson or found in *Handbook of Clinical Alcoholism Treatment*, of which Johnson is a co-author.

Currently, oral and injectable naltrexone and acamprosate are approved pharmacological treatments for alcohol dependence in addition to the old drug disulfiram.

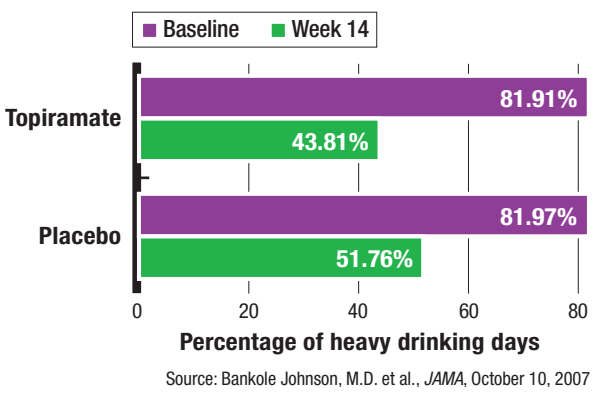
"While topiramate is not currently approved for the treatment of alcohol dependence, this is an important study to show the drug's potential effect in decreasing alcohol use in persons with alcohol dependence," said Eric Strain, M.D., professor and section head of JHB Psychiatry Substance Abuse Programs at Johns Hopkins University School of Medicine and chair of APA's Council on Addiction Psychiatry. He emphasized that available pharmacotherapy is effective for treating patients with alcohol dependence and deserves a place in the treatment plan.

"Psychiatrists should be familiar with these approved medications and knowledgeable about new medications that may soon become available to help patients with alcohol-use disorders."

An abstract of "Topiramate for Treating Alcohol Dependence" is posted at <jama.ama-assn.org/cgi/content/abstract/298/14/1641>. An abstract of "Oral Topiramate for Treatment of Alcohol Dependence: A Randomised Controlled Trial" is posted at <www.thelancet.com/journals/lancet/article/PIIS0140673603133703/abstract>. ■

Topiramate Reduces Heavy Drinking Days

Study participants with alcohol dependence taking topiramate (n=183) had a greater reduction in the percentage of heavy drinking days than those taking placebo (n=188). All participants received a weekly brief behavioral treatment. Participants who dropped out of the study were counted as relapses in the analysis.



Source: Bankole Johnson, M.D. et al., *JAMA*, October 10, 2007

NARSAD

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responses," Robert Post, M.D., chair of NARSAD's Falcone Prize Selection Committee, commented.

• **The Ruane Prize for Outstanding Achievement in Child and Adolescent Psychiatric Research** was given to James Leckman, M.D., a professor of child psychiatry at Yale University. His research has focused on autism, obsessive-compulsive disorder, and Tourette's disorder. His main research interest is the interaction between genes and environment in obsessive-compulsive disorder and Tourette's. "He has also organized one of the premier clinical and research training programs in child psychiatry, which will guarantee excellent clinical research for our next generation," Judith Rapoport, M.D., chair of the Ruane Prize Selection Committee, said.

• **The Goldman-Rakic Prize for Outstanding Achievement in Cognitive Neuroscience** was given to Huda Akil, Ph.D., a professor of psychiatry and neuroscience at the University of Michigan. Akil has made valuable contributions to understanding the neurobiology of emotions, including pain, anxiety, and depression. Early on, she and her colleagues provided the first physiological evidence for the role of endorphins in the brain and showed that endorphins are activated by stress and inhibit pain.

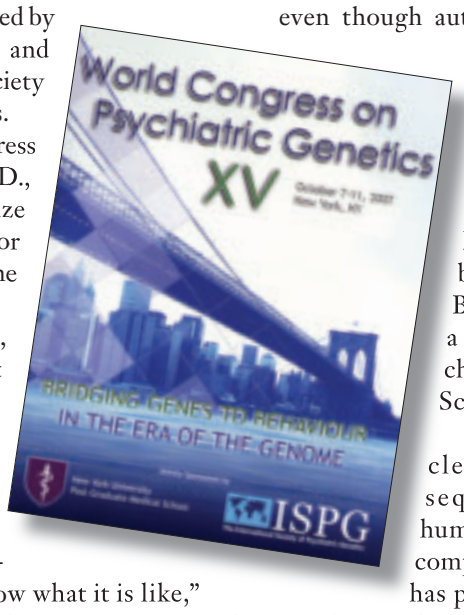
• **The Sidney R. Baer Jr. Prize for Schizophrenia Research** went to Jeremy Hall, M.D., Ph.D., a research council fellow at the University of Edinburgh in Scotland. Hall has been studying genetic factors influencing cognitive function in major mental disorders. His work integrates neuroimaging and neuropsychology with genetics. ■

Obstacles Hinder Search For Mental Illness Genes

Some 60 genes that contribute to various medical illnesses have been identified. It is likely that before long, a number of genes that contribute to psychiatric illnesses will probably have been pinpointed as well.

BY JOAN AREHART-TREICHEL

More than a thousand geneticists from dozens of countries gathered in New York in October to focus on a daunting challenge—identifying genes underlying various psychiatric illnesses. It was the 15th World Congress on Psychiatric Genetics, cosponsored by New York University and the International Society of Psychiatric Genetics.



Launching the congress was James Watson, Ph.D., who shared a Nobel Prize in Medicine in 1962 for the discovery of the structure of DNA.

During his talk, Watson noted a great irony considering the theme of the congress—he has a son with schizophrenia. "If you don't have a child with schizophrenia, you don't know what it is like," he said. Thus his family is one of many throughout the world who might profit from the identification of genes that contribute to psychiatric illness. Yet it is unfortunately going to be a while before they reap such benefits, he and other speakers indicated.

Challenges Abound

The challenges facing geneticists as they go about trying to definitively identify psychiatric genes are certainly formidable.

One of them is difficulty in replicating their findings, which in turn may be due to using too few subjects in a study or using samples that are too heterogeneous, said Markus Noethen, Ph.D., of the Life and Brain Center at the University of Bonn in Germany.

Another hurdle, speakers indicated, is that a plethora of genes with miniscule effects, not one dominant gene inherited in a Mendelian fashion, seems to underlie psychiatric disorders. For example, even though autism appears to be "overwhelmingly genetic," the evidence implies that it is due to a number of genes, and "we don't really know the real numbers," said Joseph Buxbaum, Ph.D., a professor of psychiatry at Mt. Sinai School of Medicine.

Yet another obstacle concerns the sequencing of the human genome. It was completed in 2003 and has proven to be a great boon in the search for genes that contribute to various illnesses. But also thanks to the sequencing of the human genome, geneticists are now faced with such a vast amount of genetic information that "it is really quite daunting," James Kennedy, M.D., a professor of psychiatry at the University of Toronto, admitted.

And still another difficulty is integrating findings from the current popular method of genetic analysis—genome-wide association studies—with those obtained from an earlier method of looking for psychiatric genes—linkage analysis, Pamela Sklar, M.D., Ph.D., an associate professor of psychiatry at Harvard Medical School, pointed out.

But perhaps most troubling is what Patrick Sullivan, M.D., a professor of psychiatry and genetics at the University of North Carolina, reported: candidate gene studies can produce many false positives. In fact, only a minority of association studies in biomedicine have withstood replication over time, he pointed out. To which a geneticist in the audience responded: "Nice talk! Discouraging, though."

These challenges, not surprisingly, have led to some disappointments.

Studies have suggested that there might be bipolar disorder genes on a number of chromosomes, "but none of the genes identified to date has been accepted by the scientific community," Noethen said.

"And if you think that the genes contributing to bipolar disorder are complicated, it could be that schizophrenia genes [are even more so]," Kennedy added. He and his colleagues had hoped that they could "parse out" the genes for bipolar disorder and schizophrenia, yet their efforts have been "completely unsuccessful," he said.

Unfortunately, Karola Rehnstrom, a doctoral candidate in medical genetics at the University of Helsinki in Finland, reported that the autism-gene results that she and her colleagues have obtained with genome-wide association studies do not coincide with the results that they obtained with linkage-analysis studies.

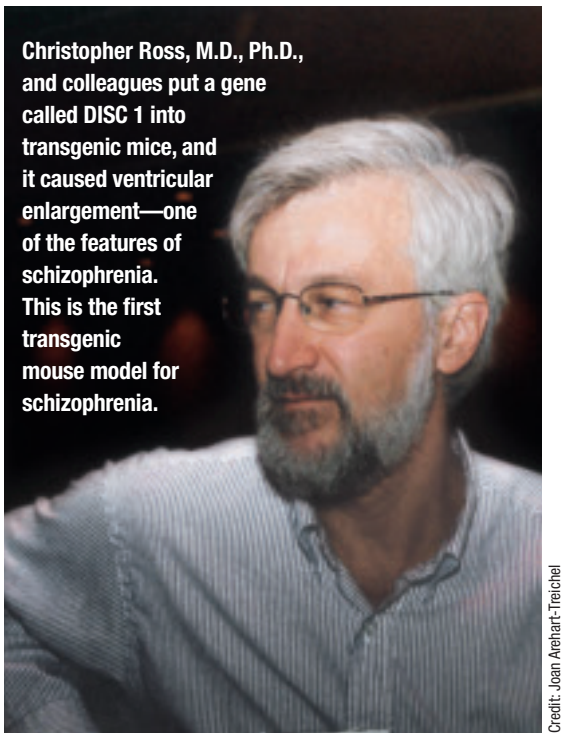
"The state of autism [gene research] is the state of psychiatric genetics," lamented Buxbaum. "We are not as far as we would like to be."

Karola Rehnstrom of the University of Helsinki in Finland: "Autism spectrum disorders have a strong genetic component, but only a few genetic causes have been identified so far."

Credit: Joan Arehart-Treichel

Some Progress Made

Nonetheless, progress has been made toward pinpointing psychiatric genes, speakers indicated.



Christopher Ross, M.D., Ph.D., and colleagues put a gene called DISC 1 into transgenic mice, and it caused ventricular enlargement—one of the features of schizophrenia. This is the first transgenic mouse model for schizophrenia.

Credit: Joan Arehart-Treichel

Several genes that contribute to Alzheimer's disease, notably the APOEe4 variant, have been identified (*Psychiatric News*, April 15, 2005).

please see ***Genes*** *on facing page*

Psychiatric Gene Researchers Urged to Pool Their Samples

The need for scientists to share DNA samples was a major theme at the World Congress on Psychiatric Genetics.

BY JOAN AREHART-TREICHEL

If geneticists want to make more progress toward pinpointing psychiatric genes, they will need to pool their DNA samples. This theme was often reiterated during the 15th World Congress on Psychiatric Genetics, held in New York City in October (see article above).

The challenge, essentially, is that a plethora of genes with small effects—not just one dominant gene with a large effect—seems to underlie psychiatric illnesses. Or as Hugh Salter, Ph.D., from AstraZeneca Research and Development stressed, "The largest problem that faces us is the small effect size for single genes."

Moreover, the major tool that geneticists wield today to pinpoint psychiatric genes is the genome-wide association study, in which the DNA of persons afflicted with a particular psychiatric illness is compared with the DNA of healthy control subjects. Yet to identify small gene effects in such studies, one may well need to use DNA taken from thousands of subjects, Francis Collins, M.D., Ph.D., director of the Human Genome Project, stated.

Thus, pooling DNA samples for genome-wide association studies would enhance geneticists' statistical power to ferret out psychiatric genes.

Some psychiatric geneticists are starting to pool their DNA samples. For example, Pamela Sklar, M.D., Ph.D., an associate professor of psychiatry at Harvard Medical School, reported that she and her colleagues have started putting their DNA material together with DNA material obtained by British scientists to speed the identification of bipolar disorder genes.

If academic geneticists want to accelerate the unmasking of psychiatric genes, they may want to share DNA samples with drug-company geneticists as well, some speakers suggested. For instance, as Bryan Dechairo, Ph.D., head of neuroscience molecular medicine at Pfizer Global Research and Development, reported, Pfizer does not lend DNA samples to academic geneticists. But Pfizer *is* willing to provide academic geneticists with information about those samples.

Such academia-industry DNA sharing may be tough to bring off, however, several geneticists cautioned. For instance, Lynn DeLisi, M.D., a professor of psychiatry at New York University and chair of the psychiatric genetics congress, said that she once shared her DNA samples with a drug company, "and it ended in a disaster for my career." The company with whom she had collaborated was bought by another company, and it took her a long time to get her DNA samples back. Scientists at drug companies are "terrific," but once the lawyers get involved and draw up contracts, that is when the trouble starts, she said.

Another reason why academic geneticists and drug-company geneticists may have trouble sharing DNA material is because they have different missions, David Porteous, Ph.D., chair of human molecular genetics and medicine at the University of Edinburgh in Scotland, pointed out. The former want to use the material to identify psychiatric genes, while the latter want to deploy it to develop new drugs. ■

Genes

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Some genes that contribute to alcoholism have also been pinpointed, John Nurnberger Jr., M.D., Ph.D., of Indiana University's Institute of Psychiatric Research added (*Psychiatric News*, April 6). One of the more interesting, he indicated, is a gene on chromosome 4 that codes for the GABRA2 receptor. This gene is also a risk factor for drug dependence, he said.

Genes on chromosomes 9 and 10 seem to be implicated in nicotine dependence, Jonathan Pollack, Ph.D., chief of the Genetics and Molecular Neurology Research Branch at the National Institute on Drug Abuse, pointed out. Furthermore, these findings have been replicated by a number of scientific groups.

According to Cathy Barr, Ph.D., a professor of psychiatry at the University of Toronto, a number of genes that may contribute to attention-deficit/hyperactivity disorder (ADHD) have been found. Some of them look especially auspicious—for example, the genes for the dopamine receptor D_4 and the dopamine transporter. Actually ADHD genes have been easier to find than geneticists expected, probably because ADHD is highly heritable, she said. Nonetheless, "each gene identified so far contributes only a small risk to the development of the disorder," she conceded.

Sklar and colleagues screened some 500,000 snips of DNA from 1,461 individuals with bipolar disorder and from 2,008 controls to try to locate bipolar genes. This was the largest single whole genome study of bipolar disorder to date, she reported. Their biggest "hit"—the gene that seemed most likely to contribute to the illness—was a gene on chromosome 12 that is involved in the passage of calcium through the cell membrane. In fact, calcium-channel blockers have been used with some success in treating bipolar disorder, so she and her colleagues are "excited" about the finding, she said.

It looks as if rare genetic errors underlie certain cases of autism, Catalina Betancur, M.D., Ph.D., of the National Institute of Health and Medical Research at the University of Paris in France reported. For instance, she and her colleagues found a gene deletion on chromosome 22 in two brothers with autism and severe mental retardation, suggesting that the gene may have contributed to both conditions.

Some more common gene variants may also contribute to autism, Buxbaum noted. "Certain candidate genes have been studied in multiple labs and are beginning to be accepted by some researchers. . . . However, no common variant is accepted. I think that is where we are today."

More Advances on Horizon

And in the rush to identify psychiatric genes, there are glimmerings of progress to come.

It is now possible to incorporate genes suspected of causing schizophrenia into mice embryos and then follow the mice's development to evaluate the impact of those genes, Christopher Ross, M.D., Ph.D., a professor of psychiatry, neurology, and neuroscience at Johns Hopkins University, pointed out. Some of those genes will probably turn out to be active in neurodevelopment, others in nerve transmission, he predicted (*Psychiatric News*, October 5).

Some geneticists are now combining two innovative techniques—genome-wide association studies and neuroimaging—in a quest to unmask psychiatric genes. One of them is Steven Potkin, M.D., of the University of California at Irvine. For instance, he and his colleagues are imaging the brains of schizophrenia subjects and controls, noting differences between the two groups, and then looking for gene variants in the former that might explain those differences. "This is just a beginning; this is new territory," Potkin said.

Indeed, as Francis Collins, M.D., Ph.D., director of the Human Genome Project, reported at the congress, some 60 genes that contribute to medical illnesses have been identified. He predicted that before long, more genes underlying psychiatric illnesses will have been found as well. For example, he said, geneticists trying to identify genes that contribute to bipolar disorder are at the point where geneticists attempting to identify genes that contribute to diabetes were somewhat earlier—they have ferreted out suspect gene areas and now need to zero in on the specific genes involved.

"I think you will find the next several years dramatic and exciting," Collins declared. ■

Priority Hotel Reservations for APA Members

Beginning Tuesday, December 4, and throughout the month of December, APA members will have an exclusive opportunity to make their hotel reservations for the 2008 annual meeting in Washington, D.C. Nonmembers who plan to attend the meeting will not be able to make their hotel reservations until Wednesday, January 2, 2008.

Information on hotels and a link to reserve a room will be accessible under Members Corner on APA's Web site at <www.psych.org>. To log on, you will need your APA membership number. Traditionally, Washington, D.C., has been a popular location for the annual meeting, so you are encouraged to make your hotel reservations as soon as possible.

More information is available by calling Vernetta Copeland (703) 907-7382.

CNS Sequelae May Appear Early in HIV Infection

Knowledge of how HIV infection causes neuropsychological impairments continues to expand, giving physicians the tools to make more accurate diagnoses and better treatment decisions.

BY AARON LEVIN

The mental health consequences of HIV infection, recognized since the early days of the epidemic, are still not entirely known, two psychiatrists said at APA's Institute on Psychiatric Services in New Orleans last month.

Epidemiological studies suggest that up to 60 percent of people infected with HIV will also experience at least one major psychiatric disorder during the course of infection.

Understanding how HIV infection disrupts the central nervous system has grown steadily over the last two decades, but the psychiatric consequences will also grow more prominent in the future as life expectancy for HIV/AIDS patients increases with better treatments, said Francisco Fernandez, M.D., and Mordecai Potash, M.D.

Early in the course of the epidemic, many scientists thought that neurocognitive effects would crop up overnight, compromising the ability of HIV-infected individuals working in critical fields such as health care, engineering, or the armed forces to do their jobs, said Potash, an associate professor of clinical psychiatry at Tulane University School of Medicine. Paradoxically, the common wisdom also held that central nervous system (CNS) symptoms occurred only after the individual progressed from HIV infection to clinically manifested AIDS.

However, that is not always the case, said Fernandez, professor and chair of the Department of Psychiatry and Behavioral Medicine and director of the Institute for Research in Psychiatry at the University of South Florida School of Medicine.

Credit: Ellen Dallager

Credit: Ellen Dallager

The clinical symptoms of HIV may at first seem like major depression or classic subcortical dementia, said Francisco Fernandez, M.D. (left), who spoke, along with Mordecai Potash, M.D., at APA's Institute on Psychiatric Services in October.

"HIV invades the CNS early in the infectious process, and psychiatric manifestations may be subtle or profound," said Fernandez, who is chair of the APA Committee on AIDS and a member of the *Psychiatric News* Editorial Advisory Board. "The acute stage of the initial infection, during the first three to six weeks, may produce cognitive or psychotic symptoms but not a decrement in function."

The risk factors run in both directions, said Potash. Not only can HIV affect the brain, but people with psychotic illnesses may underestimate their risk of infection or engage in risky behaviors that increase their chance of contracting HIV.

The effects of HIV infection occur in at least four ways. The virus may invade and damage CNS cells directly. Viral yield is low in neurons but higher in macrophages, microglia, astrocytes, or other support cells. Acting indirectly, the virus can also activate an immune cascade that can harm neurons secondarily. Finally, the immunosuppressive action of the infection can open the door to numerous infectious diseases such as toxoplasmosis, cryptococcal meningitis, tuberculous meningitis, HSV1 encephalitis, and primary CNS lymphoma.

In the earliest, asymptomatic stage, abnormalities may show up in cognitive abilities evaluated during neuropsychiatric testing but not necessarily as impairments in clinical or role functioning.

As infection proceeds to the early symptomatic stage, both tests and clinical observation provide evidence of declining function. Careful medical and neurobehavioral evaluation can help rule out primary—and treatable—nervous system diseases.

A National Institute of Mental Health consensus conference in 1989 declared that "significant impairment" occurs when tests of speed of information processing, verbal memory, or other nonlanguage tests fall two standard deviations below the mean of an HIV-negative subject. That cutoff, however, does not imply either a clinical disorder or that a dementing syndrome is present, Fernandez explained.

However, in late symptomatic infection, CNS impairment may occur in up to 60 percent of patients, either as minor cognitive-motor disease or as HIV-1-associated dementia.

The clinical presentation of HIV in the CNS resembles classic subcortical dementing processes: motor impairment, cognitive disturbance, and a predominance of apathy over depression, said Fernandez.

"This early presentation of HIV-1-associated dementia may look like major depressive disorder, with symptoms like lethargy

please see ***HIV*** *on page 23*

'Triple Diagnosis' in HIV Patients Requires Complex Treatment Course

The combination of HIV infection, substance abuse, and psychopathology presents challenges to clinicians that seem greater than the sum of the three.

BY AARON LEVIN

Psychopathology, substance abuse, and HIV infection form a grim triangle that calls for treatment approaches at least as complex as the disorders themselves, said Antoine Douaihy, M.D., at APA's Institute on Psychiatric Services in October in New Orleans.

About half of drug abusers have a comorbid mental illness, and substance abusers with HIV have high rates of psychopathology, said Douaihy, an assistant professor of psychiatry at the University of Pittsburgh School of Medicine and medical director for addiction medicine services at the Pittsburgh AIDS Center for Treatment.

Any of the three elements of this "triple diagnosis" may be associated with poor judgment, high-risk behavior, and impulsivity.

Many substance users have depression, schizophrenia, schizoaffective disorder, or borderline personality disorder. Substance use, especially injection drug use, frequently co-exists with other psychiatric symptoms such as impulsivity, cognitive impairment, or hypersexuality, any of which can increase HIV risk.

"The link is strong in any direction," he said. "This is a population at significant risk for HIV infection."

Triple-diagnosis patients may also face unemployment, poverty, poor housing, legal problems, and lack of social support, among other difficulties.

Credit: Ellen Dallager

Patients with a "triple diagnosis"—mental illness, substance abuse, and HIV infection—face daunting problems and need integrated treatment for the first two before starting antiretroviral therapy, said Antoine Douaihy, M.D.

Although antiretroviral treatment of HIV has become standard, poor adherence to treatment among a dually diagnosed population with the infection lowers the chances of successful anti-HIV therapy.

"Active drug use is associated with low adherence to antiretroviral therapy," said Douaihy. "Therefore it is not advisable to start antiretroviral treatment until the patient's addiction and psychiatric problems are stabilized."

Rather than exclude patients from treatment, however, Douaihy suggests a multipronged approach to care. Dual-diagnosis patients often get tracked into either the mental health or the substance abuse systems, but an ideal system would include services for drug withdrawal, general medical care, substance abuse treatment, and other psychiatric treatment at the same site. That not only reinforces compliance but lessens chances for missed appointments when patients are referred off site.

"The sequential approach works poorly," said Douaihy. "Effective services require an integrated approach. Common sense is more important than special expertise."

While an effective integrated program includes coordinated mental health, substance abuse, and medical aspects of the patient's care, he said, it may also require case management, assertive outreach, group therapy, psychotherapeutic interventions tailored to the patient's readiness for change, motivational strategies, special attention to psychosocial needs, strong emphasis on psychoeducation, psychopharmacologic management, and behavioral strategies to help the patient through both easy and difficult times.

please see ***Triple Diagnosis*** *on page 22*

Combat Veterans With PTSD Benefit From Online CBT

Therapy over the Internet may expand access to treatment for traumatized survivors of war or terrorism.

BY AARON LEVIN

A test of self-managed cognitive-behavioral therapy (CBT) conducted live over the Internet with therapists may expand treatment options for military personnel with posttraumatic stress disorder, if results from a small, proof-of-concept trial are any indication.

"Most people don't get the help they need following mass trauma or war," said Brett Litz, Ph.D., lead author on the study, which appeared in the November *American Journal of Psychiatry*, in an interview. "They need constant face-to-face care with experts, and that's not a reality."

Most studies on PTSD treatments have been carried out among veterans or civilian victims of trauma. To his knowledge, this was only the second randomized, controlled study of a mental health intervention held within the Department of Defense.

The trial was not "computer therapy," Litz emphasized. Computers and the Internet were simply the vehicles for delivering the service. The real work involved interactions between patients and clinicians, he said. "At the 'back end,' therapists could follow each patient, monitor any regression, and produce daily ratings."

Litz, of the Boston Veterans Affairs Healthcare, Boston University School of Medicine, and the National Center for Posttraumatic Stress Disorder, collaborated with Charles Engel, M.D., M.P.H., of the Uniformed Services University of the Health Sciences; Richard Bryant, Ph.D., of the University of New South Wales in Australia; and Anthony Papa, Ph.D., of Boston University School of Medicine.

The intervention was geared toward the needs of military service members, who are often short of spare time and are concerned about the stigma attached to issues of mental illness, said Litz.

Their patients were service members who developed PTSD following the September 11 attack on the Pentagon or after combat in Iraq or Afghanistan. The researchers screened 141 volunteers and recruited 45 for random assignment, of whom 33 completed the treatment protocol. Subjects were initially assessed in face-to-face sessions with therapists using the PTSD Symptom Scale–Interview Version, the Beck Depression Inventory-II, and the Beck Anxiety Inventory. They were evaluated again after eight weeks of treatment (permitting up to 56 possible sessions), and at three and six months after baseline.

Litz and colleagues titled their program DESTRESS—DElivery of Self-TRaining and Education for Stressful Situations—as a way of reducing stigma and emphasizing self-care aspects.

In the CBT arm, patients learned coping skills through homework assignments to handle the inevitable stressful situations they encountered in daily life, said Litz.

After learning those stress-management strategies, they began graduated exposure to the triggers, followed by seven online sessions during which they wrote about their traumas. "The goal was to promote mastery and reduce avoidance," said the researchers. They also had access by phone or e-mail to their therapists, who included psychologists and a social worker.

The second study arm consisted of a control group of 21 patients who received supportive counseling and were asked to monitor nontrauma-related, present-day concerns and write about those experiences. Both groups also had Web access to educational materials about PTSD, stress, trauma, depression, and strategies to manage anger or sleep problems.

The PTSD symptoms of patients improved in both study arms, although the CBT intervention produced a sharper decline in severity. Of the 33 patients who completed the eight weeks of CBT treatment, 24 were assessed at the three-month follow-up, and 18 at the six-month follow-up. At three months, there was no difference between those who did or did not complete the protocol, but at six months, completers in the self-management CBT arm had significantly fewer PTSD, depression, and anxiety symptoms.

The difference at six months between the two arms might be explained by the better strategies absorbed by the CBT patients, said Litz.

"They learn to manage challenges," he said. "That ability sinks in with sufficient successful experience, and it builds confidence in self-efficacy."

The intervention also made good use of the therapists' time. They were able to look after more patients than they would in a similar number of office visits, said Litz. "The net time per case probably averaged about 15 minutes per week over the course of the eight weeks."

This study is just the beginning of research using this style of intervention, said Litz. Members of the research team will continue to study its utility in U.S. Marines newly returned from Iraq and also in primary care settings at Fort Bragg, N.C., and at the Charleston (S.C.) Veterans Affairs Medical Center.

"A Randomized, Controlled Proof-of-Concept Trial of an Internet-Based, Therapist-Assisted Self-Management Treatment for Posttraumatic Stress Disorder" is posted at <http://ajp.psychiatryonline.org/cgi/content/full/164/11/1676>. ■

Conscientiousness May Be Buffer Against Alzheimer's Disease

Just as neuroticism may be linked with Alzheimer's disease risk, conscientiousness may offer protection from it. Three other personality traits do not seem to be related to the disease.

BY JOAN AREHART-TREICHEL

In 1994 some 1,000 older Catholic priests, nuns, and brothers signed up for a mission that had nothing to do with saving souls but plenty to do with preventing illness.

The mission was called the Religious Orders Study. They were evaluated medically, neurologically, cognitively, and psychologically and have been tracked since to see which ones develop Alzheimer's disease. Differences between those who develop Alzheimer's and those who do not are then being analyzed to identify factors that might predict subsequent susceptibility to Alzheimer's.

One of the factors that the study has identified is rapidly progressing Parkinson's disease (*Psychiatric News*, June 20, 2003). Still another is neuroticism, that is, an enduring tendency to experience psychological distress (*Psychiatric News*, July 20). And now still another has been suggested—that a higher level of conscientiousness is linked to a reduced risk of developing Alzheimer's.

The lead author of this latest assessment, as well as the previous ones, was Robert Wilson, Ph.D., a professor of neuropsychology at Rush University Medical Center in Chicago. Results were published in the October *Archives of General Psychiatry*.

In 1994 Wilson and his group used the NEO Five-Factor Inventory to assess five personality characteristics in the study participants. One of these characteristics was conscientiousness, which, as the researchers pointed out, means a tendency to be self-disciplined, goal directed, willing to work, painstaking, and dependable.

Study participants read 12 statements concerning conscientiousness, such as "I am a productive person who always gets the job done," then rated themselves on a scale of 0 to 4, with higher scores indicating more conscientiousness. The highest possible score was 48. The participants had conscientiousness scores ranging from 11 to 47, with an average of 34.

By 2006, 12 years after the study started, 176 of the study participants had developed Alzheimer's disease, and the researchers assessed whether there was any link between study participants' conscientiousness scores at the start of the study and their susceptibility to Alzheimer's during the 12-year follow-up, taking three factors known to influence Alzheimer's—age, gender, and education—into consideration.

Their Alzheimer's risk decreased by more than 5 percent for each additional point they obtained on the conscientiousness yardstick. Thus, those subjects who had conscientiousness scores in the 90th percentile (40 points) or higher at the start of the study, had an 89 percent lower risk of developing Alzheimer's than did those whose scores had ranked in the 10th percentile (28 points) or lower at the start of the study.

The researchers then repeated their analysis, taking other Alzheimer's risk factors into consideration. The factors were neuroticism, physical activity, cognitive activity, size of the social network, possession of the APOE-e4 gene variant, vascular disease, depressive symptoms, and mild cognitive impairment. Again the link between conscientiousness and risk of Alzheimer's held firm.

However, the reason why conscientiousness seems to augur protection against Alzheimer's is not clear, Wilson and his group acknowledged, noting that conscientiousness seems to be protective against other mental and physical illnesses as well, "suggesting that the trait has some general role in health maintenance."

The role may have something to do with safeguarding cognition, the researchers suggested. This might be the case, they explained, because at the start of the study, the cognitive skills of highly conscientious subjects were comparable to those of less conscientious ones, yet as time went by, those skills declined much less in the more conscientious individuals.

But how might conscientiousness help safeguard cognition? Conscientiousness has been linked with a higher level of resilience and greater reliance on task-oriented coping, the researchers pointed out. Thus these factors might buffer cognition from the adverse consequences of negative life events, and cognition shielded from such adverse consequences might then be better armored against Alzheimer's, they proposed.

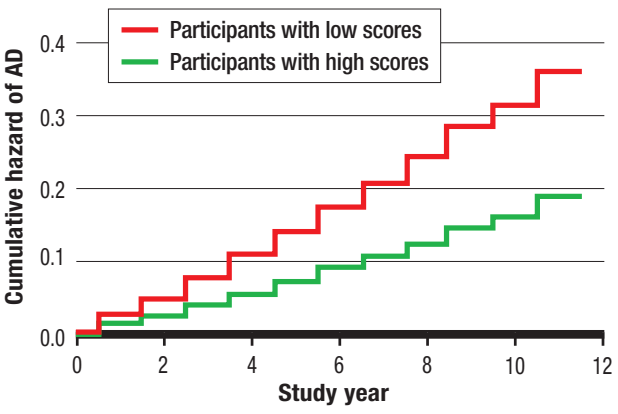
"Understanding the mechanisms linking conscientiousness to maintenance of cognition in old age may suggest novel strategies for delaying the symptoms of Alzheimer's disease," Wilson and his team concluded.

The study was funded by the National Institute on Aging.

An abstract of "Conscientiousness and the Incidence of Alzheimer Disease and Mild Cognitive Impairment" is posted at <http://archpsyc.ama-assn.org/cgi/content/abstract/64/10/1204>. ■

Well-Done Job May Lead To Unexpected Bonus

In a study of 997 older Catholic nuns, priests, and brothers without dementia at enrollment, individuals with a higher level of the personality trait of conscientiousness had an 89% reduction in the risk of developing Alzheimer's disease compared with those low in conscientiousness. Researchers used a standard 12-item measure of conscientiousness.



Source: Robert Wilson, Ph.D., et al., *Archives of General Psychiatry*, October 2007

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Schizophrenia

continued from page 14

sis of schizophrenia, schizoaffective disorder, or schizophreniform disorder for no longer than one year; had been treated with antipsychotic medication for no longer than 12 weeks; had no more than two hospitalizations during the index year; and were between the ages of 16 and 45.

Schooler said that study and many others have confirmed the remarkably rapid efficacy of medication in resolving the positive symptoms of schizophrenia in most first-episode patients. That success

"I would argue that we know how to treat the disorder acutely. The real issue is how to go on to long-term pharmacologic treatment."

is typically greeted ecstatically by patients and family members, who are apt to present initially in a highly fearful and confused state of mind.

This is in marked contrast to chronic patients, for whom response to antipsychotic medication may not be so quick, and who have developed strategies of adaptation over many years of experiencing symptoms.

"When chronic patients experience a recurrence they are liable to think, 'Oh, yes, here are those symptoms again,'" she said. "It may be frightening, but parts of the experience are familiar.

"In contrast, first-episode patients have a real inability to distinguish their symptoms from reality," Schooler said. "The degree of conviction with which the delusions and hallucinatory experiences are accepted as real is profound.

"And family members usually are extremely fearful. They say, 'This is not my son; I don't know what to make of it,'" she added. "Everyone is inexperienced, and they don't where to go. So the idea that this is an illness can be very difficult to convey."

Success Has a Downside

But the typically rapid success of antipsychotic medication in resolving positive symptoms in first-episode patients can have a downside.

"The experience most people have had with medicating other illnesses is that when they get better, they stop taking the medication and are done with it," Schooler said.

So a crucial issue in psychosocial education of patients and families is helping them to understand that this is an illness they are likely to be dealing with for years. Also, the vast majority of patients who discontinue medication will experience recurrence of symptoms, Schooler strongly believes.

"The question is when they will invariably relapse," she said.

Schooler said the "stress diathesis" model—in which schizophrenia is conceptualized as a biological and genetic disorder brought to the fore by environmental stressors—is generally one that patients and families accept and understand. It can be a useful clinical tool in introducing them to the need to avoid returning immediately to pre-illness situations that are liable to be stressful and to exacerbate symptoms.

Schooler also described a model for introducing patients and families to the need for long-term treatment built on a foundation of therapeutic trust in which clinicians, patients, and family members are involved together in evaluating progress in the hospital and monitoring the transition from the hospital to the community and into a program of maintenance therapy.

The model was used for research purposes as part of the Prevent First-Episode Relapse (PREFER) study, which was designed by Schooler and principal investigator Peter Weiden, M.D., a professor of psychiatry and director of the psychotic disorders program at the University of Illinois at Chicago. But Schooler said she believes the model translates well into a clinical setting.

In that study, patients were random-

clinical & research news

Triple Diagnosis

continued from page 18

An integrated treatment plan usually occurs in stages—engagement, persuasion, active treatment, and relapse prevention—to ensure optimal timing of interventions, he said. "If one is missing, the process collapses and more problems arise."

In addition, it is crucial that all clinicians who care for these patients be aware of interactions between antiretroviral drugs and other substances likely to be found in these patients. Methadone levels, for instance, may rise, fall, or remain the same, depending on which antiretroviral is prescribed. Antiretrovirals or protease inhibitors may also amplify effects of street drugs like heroin, amphetamines, and ecstasy.

Douaihy also seeks to involve "concerned significant others" in the patient's care—family and friends who form a helping social network. A long-term perspective helps too. The best predictors of positive outcomes are the strength of the therapeutic alliance and the duration of care, he pointed out.

However, the most important elements in treatment are engagement and motivation, he said. He rejects programs that discharge patients when they have problems. "I tell patients, 'I want to see you when you're having a hard time—when you're relapsing or having worse symptoms.'"

A fact sheet from APA, "HIV and Substance Use," is posted at <www.psych.org/AIDS/substanceusecr06-05.pdf>. ■

ized to receive a recommendation for oral treatment or long-term injectable risperidone microspheres. Patients could refuse the long-acting injectable medication, and those who did were treated with an appropriate oral antipsychotic.

Schooler said the benefit of injectable medication is the much improved ability to monitor compliance. "You know the minute a patient is nonadherent because he or she doesn't show up for the injection," she said.

But she said preliminary results from the PREFER study confirm the generally sobering picture for long-term treatment of schizophrenia—a substantial percentage of patients in both treatment arms ceased to take medication for at least two weeks within a 12-week period.

She noted that even with antipsychotic medication, there tends to be an "inexorable course of relapse." Moreover, studies of outcome using criteria for "recovery" are equally disquieting; few patients are likely to return to normal social and occupational functioning five years after first treatment, she said.

For these reasons, Schooler said she believes the future of psychiatric treatment for first-episode patients with schizophrenia lies in facilitating and improving long-term maintenance care.

"I would argue that we know how to treat the disorder acutely," she said. "The real issue is how to go on to long-term pharmacologic treatment."

"Risperidone and Haloperidol in First-Episode Psychosis: A Long-Term Randomized Trial" is posted at <http://ajp.psychiatryonline.org/cgi/content/abstract/162/5/947>. ■

HIV

continued from page 18

and social withdrawal, forgetfulness, poor concentration, an unsteady gait, and difficulty with once-familiar tasks," he said.

Antiretroviral treatment—sometimes with "industrial-grade doses"—may not only reduce symptoms "below the neck" but also help with CNS function, especially if started early to minimize CNS damage. Other drugs may be effective, too. Methylphenidate, for example, can improve reaction time and performance tasks and aid memory, although it should be avoided in patients with a history of psychotic symptoms or seizures, said Fernandez.

Potash also suggested caution in the use of antipsychotic drugs for patients with HIV.

"The destruction by the virus of cells in the basal ganglia appears to prime the brain for increased extrapyramidal side effects following use of typical antipsychotics," he said. "I suggest using atypical antipsychotics as first-line therapies, starting with low doses. Treat patients for as short a time as possible—only as long as symptoms persist."

Knowledge of the interplay between HIV and psychosis is still incomplete and is likely to change quickly as research in neuropsychiatry, pharmacology, and infectious diseases progresses, said Potash. The work of individual psychiatrists with even one or two patients can contribute to this development and stimulate research if communicated to the field through case reports to journals, he concluded. ■

Advocacy

continued from page 1

public discussion of mental health needs for our wounded warriors and their families has served to destigmatize mental illness, just as the disclosures by prominent politicians and entertainers did in the past decade."

Robinowitz said that widening acceptance of the value of mental health services—as exemplified by the advance of federal legislation granting parity insurance coverage for mental health treatment—has been matched by an expanded scientific understanding.

"We now have ever more intricate and complex understanding of both brain and mind function, from the molecular and genomic to behavioral levels," she said. "Sophisticated imaging techniques can not only localize functions but demonstrate the impact of therapies—psychotherapies as well as pharmacologic. There is scientific recognition that physical health and mental health go hand in hand. . . . We no longer need to feel inferior to our colleagues in other medical settings in terms of the evidence supporting our approaches."

But she emphasized that these benefits have not been extended to large portions of the U.S. population, as evident in the staggering numbers of mentally ill people in the nation's jails and prisons and in the chronic underfunding of community mental health services.

And she referenced a study released this year by the American Psychiatric Institute for Research and Education documenting the dramatic impact—measured in emergency department visits, homelessness, and recurrence of disease in previously stable patients—of the transition to the Part D Medicare prescription drug program for dually eligible mentally ill patients who used to get their drug coverage under Medicaid (*Psychiatric News*, May 18, July 20).

Robinowitz also drew attention to a study appearing in the September *American Journal of Psychiatry* documenting a dramatic increase in youth and adolescent suicide coinciding with a sharp reduction in antidepressant prescribing in the period following the FDA's public health advisory and "black-box" warning regarding antidepressant use and suicide (*Psychiatric News*, October 5).

She emphasized the critical importance of advocacy efforts in meeting the challenges facing the mental health system at the federal and state levels, with the business community, and in partnership with other advocacy groups. She challenged APA members at the institute to question whether they were doing enough to improve the system.

"We believe we are part of the solution, but are we also contributors to these problems?" she asked. "How often, loudly, and effectively do we advocate for our patients? We are busy caring for them, but in this world, that is insufficient. We are the only ones who can integrate the needs of patients and our care systems. We are the only people who can provide access to care, assess the care, and ensure quality, integrating biological, psychological, and social factors. So we have an intellectual as well as moral authority to commit to our core professional values and protect our patients without being paternalistic or maternalistic." ■

Antipsychotics

continued from page 1

results were compared with performance on the same tests by 84 healthy controls, who were also tested three times.

Neurocognitive tests included measures of working memory and attention, speed, motor function, episodic memory, and executive function.

No differences in effects were observed between the two drugs; both produced dramatic improvements in positive symptoms, with cognitive improvements demonstrated for both drugs on nine of the cognitive measures.

But only two measures demonstrated greater rates of change than those observed in the healthy control group undergoing repeated assessment,.

"We think it's a practice effect," Goldberg told *Psychiatric News*. "That's inferential, but if it looks like a duck and quacks like a duck, it's probably a duck." He added that it is known that schizophrenia patients can demonstrate practice effects; that is, they are capable of learning tasks in a test environment and improving them through repetition.

"Practice effects are better than nothing, but they don't translate out of the laboratory into the real world," he said. "What this suggests is that the drugs may not really be changing the compromised neurobiology that underlies cognitive deficits."

William Carpenter, M.D., director of the Maryland Psychiatric Research Center, who has been critical of manufacturers' claims for cognitive effects of second-generation antipsychotics, said the study is persuasive.

"It is critical that we not misjudge the efficacy evidence for any drug tested for cognition in schizophrenia," Carpenter said. "Studies to date show either little or no benefit for cognition with the antipsychotic drugs. When a benefit is observed, many explanations other than efficacy have to be considered. Substantial doses of haloperidol have been the common comparator, and superiority of a new drug may simply reflect less adverse effect on cognition.

"This may be why neurocognitive advantages tend to disappear when compared with low-dose haloperidol, or to perphenazine as in the CATIE [Clinical Antipsychotic Trials of Intervention Effectiveness] study," Carpenter added. "Goldberg's demonstration of improved testing scores simply reflecting learning or practice effects is crucial because of the tendency to interpret any improvement over time as due to drug benefit."

"Cognitive Improvements After Treatment With Second-Generation Antipsychotic Medication in First-Episode Patients: Is It a Practice Effect?" is posted at <http://archpsy.ama-assn.org/cgi/content/full/64/10/1115>. ■

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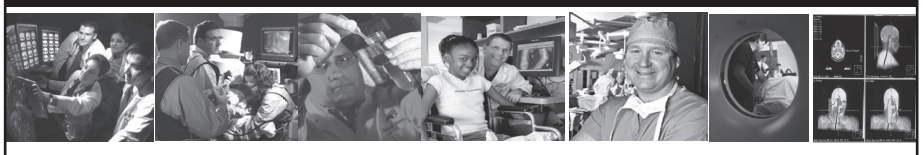

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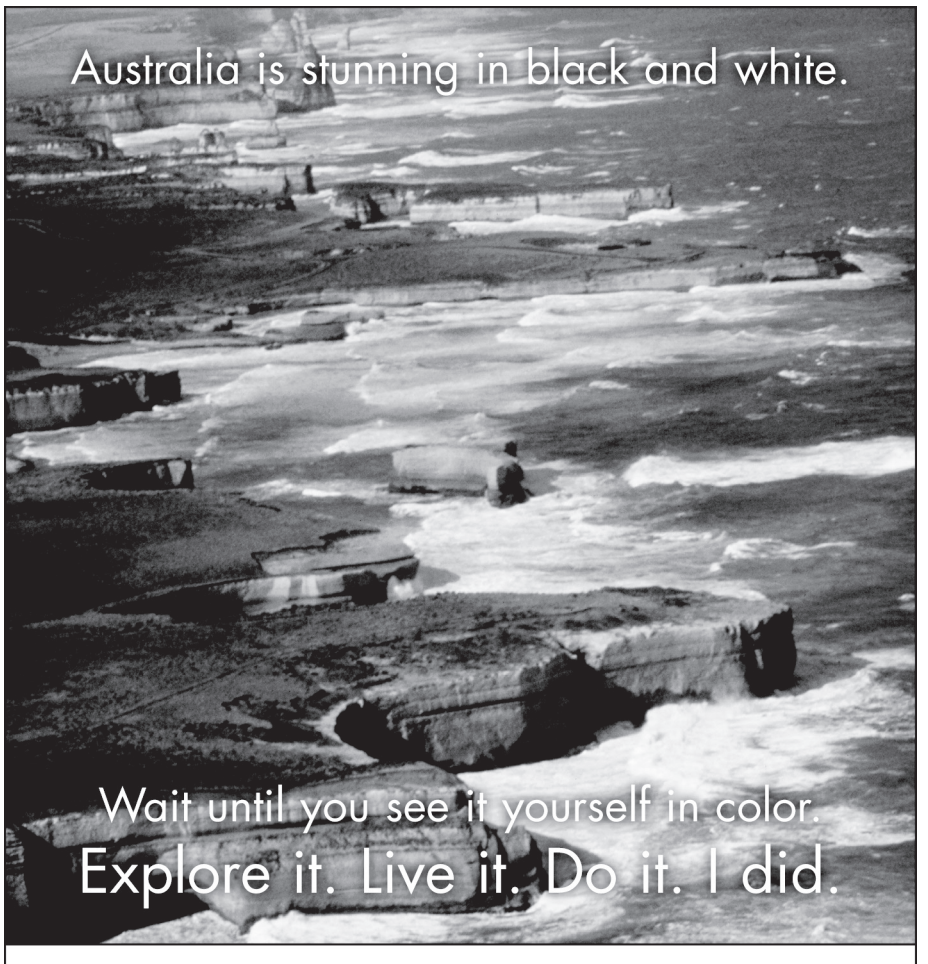

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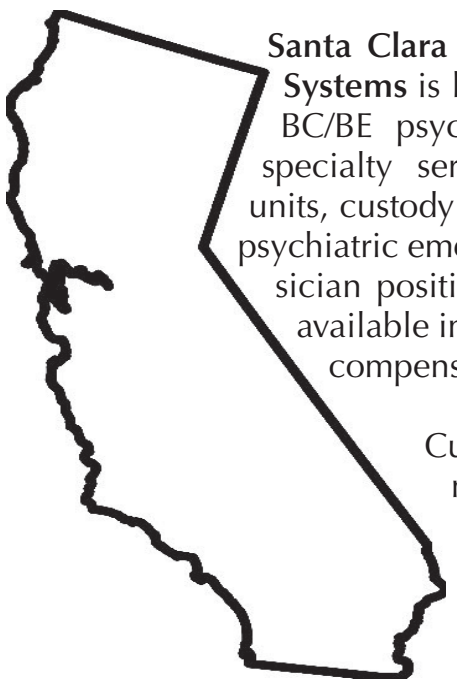

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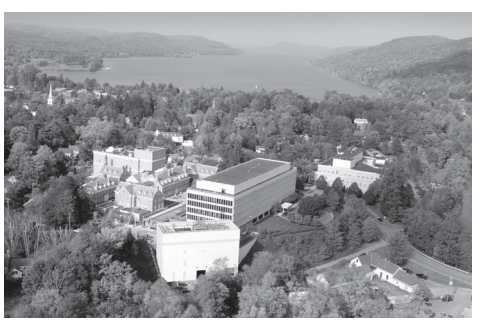

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Email: lrhines@freemanhealth.com
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FACULTY PSYCHIATRIST OPPORTUNITIES

Adult Inpatient/Outpatient & Partial Hospital

Baystate Medical Center's Department of Psychiatry at Baystate Medical Center in Massachusetts is actively seeking Board-certified psychiatrists for its interdisciplinary Outpatient and Inpatient Services, and the Adult Partial Hospital Program. Duties include collaboration with highly skilled multidisciplinary teams, patient care, and teaching. As the Western campus for Tufts University School of Medicine, Baystate Medical Center provides educational opportunities for medical students and is developing a residency program in psychiatry. Research opportunities are available and those with an interest in teaching are encouraged to apply.

Baystate is one of New England's largest integrated multi-institutional healthcare systems and offers a coordinated continuum of hospital, physician services, and home healthcare services. The campus is located in the beautiful Connecticut River valley of Western Massachusetts, at the foothills of the Berkshires with convenient access to coastal New England, Vermont, and metropolitan Boston and New York. The area also supports a rich network of academic institutions including the University of Massachusetts and Amherst, Smith, Hampshire, and Mount Holyoke Colleges. The Baystate continuum includes Baystate Medical Center, Franklin Medical Center, and Baystate Mary Lane Hospital. Baystate Medical Center (BMC) is designated a Magnet™ hospital for excellence in nursing services by the American Nurses Credentialing Center (ANCC). Baystate Health is ranked in the top 50 most highly integrated healthcare networks in the United States.

Baystate Medical Center, recently named one of America's 100 best hospitals, is the health system's flagship hospital. It has over 650 beds and residency and fellowship programs in medicine, surgery, anesthesiology, radiology, pediatrics, obstetrics/gynecology, emergency medicine, and pathology. Baystate Medical Center serves as the regional referral center for Western New England.

Interested applicants should submit a CV and cover letter to:

Benjamin Liptzin, MD, Chairman of Psychiatry
Baystate Medical Center, 759 Chestnut Street, Springfield, MA 01199
Telephone: (413) 794-4235; Fax: (413) 794-5059
Email: Benjamin.Liptzin@bhs.org
EOE/AA

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888.357.7924

PSYCHIATRISTS

The Department of Veterans Affairs, Central Texas Veterans Health Care System (CTVHCS), is accepting applications for several positions for board-certified Psychiatrists at Temple and Waco, Texas. CTVHCS is affiliated with the Texas A&M University Health Science Center. Applicants with interest in teaching and research will be given preference. CTVHCS offers competitive salaries and excellent benefits.

Applicants are required to have expertise in treatment of at least one of the following patient populations: the seriously mentally ill, PTSD, or provision of mental health in primary care clinics.

In addition to its close proximity to the metropolitan Austin area famous for its live entertainment, Central Texas offers affordable housing, excellent schools, one of the lowest costs of living in the country, and year-round recreational opportunities highlighted by the lakes and rivers of the Texas Hill Country. Texas has no state income tax.

Candidates must be US citizens or permanent residents, as well as possess a valid and unrestricted medical license in at least one state. Reasonable accommodation provided to any applicant with disabilities. Applicants are subject to drug testing. EOE

Please Fax or send CV to:
Donna Zimmerman, Physician Recruiter
Central Texas Veterans Health Care System
1901 Veterans Memorial Drive, Temple, TX 76504
FAX (254) 743-1412, Voice (254) 743-0049
E-mail to: Donna.Zimmerman@va.gov

COALINGA STATE HOSPITAL

Get in on the ground floor!

Coalinga State Hospital, in conjunction with UC Irvine, is inviting applications for psychiatrists.

Coalinga State Hospital is the first new State psychiatric hospital built in California in over 50 years. With its 1,500 beds, almost exclusively devoted to the treatment of sexually violent predators, it is a state-of-the-art facility. It is closely affiliated with the University of California, Irvine School of Medicine, and will train medical students and residents. A forensic fellowship program is being developed.

This is an excellent opportunity for a Board Certified or Board Eligible clinician interested in general adult psychiatry as well as forensic psychiatry. Coalinga State Hospital's salary package is competitive and we offer job security, flexible work schedules, and a generous California State benefit package, including paid leave, medical insurance, and CalPERS Retirement. J-1 visa applicants accepted.

Call us today regarding impending salary increases!

Coalinga State Hospital is a young organization with an idealistic staff. We invite you to come and visit our new facility and to meet our staff; travel expenses may be covered. Coalinga is located in the San Joaquin Valley, equidistant from Los Angeles, San Francisco, and Sacramento, and only two hours from the coast and National Parks.

If you are interested in discussing any of our psychiatric positions, please contact.

Barbara Morris
(559) 935-7275
BMorris@csh.dmh.ca.gov

www.dmh.ca.gov/Statehospitals/Coalinga
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CALIFORNIA DEPARTMENT OF Mental Health

PSYCHIATRISTS

The correctional mental health care field is among the fastest-growing segments of behavioral health today, and **MHM Services** is America's progressive leader in that dynamic field. Here, you'll be serving one of the most clinically interesting and medication -compliant populations. You will also have the time to initiate change, track progress and conduct more follow-up than you would in other settings.

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Our incomes average higher than those in other mental health settings, and you will enjoy regular working hours. Our extraordinary benefits include paid malpractice insurance, and much more. National Health Service Corp (NHSC) Loan Repayment Program is available, as well as J-1 and H1B Visa Waivers.

Psychiatrist *positions are available in the following locations:*

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Hagerstown, MD • Columbus, OH • Lima, OH • Ocala, FL • Jacksonville, FL
Pensacola, FL • Ft. Myers, FL • Montgomery, Alabama • Michigan (statewide)

For information or to apply, contact: **Dawn Sechrest** at: **(866) 604-2800** or e-mail resume indicating desired location to: **dsechrest@mhm-services.com**. Visit our website at: **www.mhm-services.com**

MHM Services, Inc.

EOE

VA Healthcare VISN 4

The Coatesville VA Medical Center is seeking board certified/eligible psychiatrists for the following positions:

- Psychosocial Rehabilitation Treatment Unit
- Substance Abuse Treatment Unit – Program Director: Addiction or ASAM Certified
- Outpatient Psychiatrists: with or with geriatric interest.

The Coatesville VAMC is a 472-bed facility with psychiatry, primary care and nursing home units that serves as the tertiary referral center for the eastern half of Veteran's Integrated Service Network 4 (PA, NJ, DE) for veterans who have served our nation from World War I to the Global War on Terror. All the units have PAs/Internists managing medical issues.

The incumbents will not only have a strong commitment to caring for those who served our nation but must also possess excellent communication, clinical, and interpersonal skills in his/her role as a member of an interdisciplinary team. There is no interaction with Managed Care Agencies or Treatment Authorizations. Medical records are electronic and a working knowledge and comfort with computers is a must.

Newly hired staff at the medical center are eligible to apply for our Education Debt Reduction Program. Consideration may be given for relocation pay and/or recruitment pay.

Coatesville VA medical center is located approximately one hour west of Philadelphia with its numerous cultural and sporting venues. NYC and DC are two-hour driving distance. There are numerous institutions of higher education, including medical schools, in the area. The local community offers affordable living and quality public and private schools with diverse recreational activities.

Forward resume to:

Coatesville VA Medical Center (11D)
1400 Blackhorse Hill Rd
Coatesville, PA 19320
Attn: Robert T. Marshall, AA/COS
Phone: 610-383-0219; Fax: 610-380-4391

MILLER SCHOOL OF MEDICINE
UNIVERSITY OF MIAMI

Department of Psychiatry and Behavioral Sciences

The Department of Psychiatry and Behavioral Sciences, Miller School of Medicine, in affiliation with Jackson Memorial Hospital, announces a new Schizophrenia Research Fellowship. Individuals who have completed a general residency in Psychiatry and have an interest and commitment to an academic and research career may apply. The one year experience under the direction of Drs. Ewald Horwath and Richard Steinbook with the collaboration of Drs. Julio Licinio, Marvin Herz, and Ma Li Wong, will train the fellow in the latest advances in genetics, epidemiology, neuroendocrinology, brain imagining, and the neurophysiology of schizophrenia.

The individual will also be provided with experiences in ongoing psychopharmacological studies, some of which are part of the NIMH-funded Schizophrenia Trials Network and some funded by private industry. The fellow will have the opportunity to develop his/her own projects and learn statistical methods, grant writing, structuring research proposals presentations and publications.

Application attention to:

Richard Steinbook, M.D. (D-29)
Department of Psychiatry and Behavioral Sciences
1695 NW 9th Ave., Rm 2101
Miami, FL 33136
rsteinbook@med.miami.edu

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Chris Cullum, Human Resources – 618-997-5311 ext. 55563
Dr. Lisa McCutchen, Care Line Director – 618-997-5311 ext. 54161
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The County of Riverside in beautiful Southern California is seeking general adult and sub-specialty trained psychiatrists to serve the growing needs of clients in our rapidly expanding County-operated public mental health system.

We offer excellent compensation for psychiatrists through regular employment (up to: $218,000, non-Bd.C., $230,303, Bd.C., $242,243, Mult.Bd.C.) with a great benefit package, including County payment of employee contributions to the Public Employee Retirement System (PERS) equal to 8% of salary with retirement formula 3%@60, or hourly Per Diem rates. We provide additional compensation for inpatient and jail services. Psychiatrists are needed for psychiatric ER, outpatient clinics and correctional work throughout our large geographic area, including Riverside, the **Palm Springs/Indio** area, and other smaller rapidly growing communities in the County. California license required.

Join our team of competent, committed, and caring medical staff. Live and work in our ideal climate within close proximity to Southern California beaches and the greater L.A. metropolitan areas' vast array of cultural, educational, sporting and recreation opportunities, with some of the most affordable housing in California.

If you are interested in discussing any of our psychiatric positions, please contact:

Jerry L. Dennis, MD, Medical Director
951-358-4621

and send your CV to:

Tiffany Mott
County of Riverside
Department of Mental Health
4095 County Circle Dr.
Riverside, Ca. 92503
tmott@rc-hr.com

Riverside County
COUNTY OF RIVERSIDE · MAY 9, 1893
Beyond Your Expectations

The Department of Psychiatry at The University at Buffalo is seeking an academic psychiatrist at the Assistant, Associate or Professor level with the interest and potential to develop a sustained, independent research program. This is a tenure track position with 50% fully protected time for the successful applicant to develop their research program. Resources for this recruitment include financial support for 1 to 2 additional faculty to work closely with the successful candidate and for part-time secretarial support. We are particularly interested in clinical scientists with established research programs in cognitive/behavioral neuroscience, clinical trials research, clinical psychopharmacology, psychoneuroimmunology, clinical/genetic epidemiology, or PTSD/mood disorders. Salary and benefits are excellent and commensurate with qualifications.

Qualifications: Successful candidates should have strong research credentials, ideally with current or recent funding as a principal investigator. Investigators whose research programs are closely associated with their clinical work are of particular interest.

The Department of Psychiatry and the School of Medicine have outstanding resources. The Department has an excellent reputation in the medical school and has a prominent teaching program for medical students. The residency programs in general psychiatry and child/adolescent psychiatry are thriving and there is a new geriatrics fellowship. The University and Chair are committed to expanding the research capacities of the Department. The School of Medicine and Biomedical Sciences has organized a consortium of affiliated hospitals offering a wide range of clinical settings and Department of Psychiatry faculty treat patients in many of these settings. This represents a rich and diverse source of potential participants for research programs. In addition, the department maintains relationships with a number of other research and health centers that provide opportunities for collaborative research, including the Buffalo Center of Excellence in Bioinformatics, the Roswell Park Cancer Institute, the UB-VA Center for Positron Emission Tomography, the Research Institute on Addictions, and The VA Western New York Healthcare System with a primary site in Buffalo.

Women and minorities are encouraged to apply.
The University at Buffalo is an Equal Opportunity/Affirmative Action employer.

Send cover letter describing clinical and research interests, resume, sample publications, and three letters of recommendation to:

Ken Leonard, Ph.D.,Vice Chair for Research, Director of Psychology in Psychiatry
Erie County Medical Center
462 Grider Street
Buffalo, NY 14215
kleonard@buffalo.edu

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH SOUTHEASTERN AREA

Exciting opportunity for Board Certified or eligible psychiatrists to lead clinical teams at Taunton State Hospital, a facility of the Massachusetts Department of Mental Health. TSH is a 166-bed Joint Commission accredited hospital that provides care to both forensic and continuing care patients and is affiliated with the Harvard South Shore Psychiatry Residency Program providing opportunities to supervise trainees and to pursue academic interests. You will be an integral member of a dynamic area team engaged in a full spectrum of psychiatric care from inpatient to community living.

Unique full- or part-time psychiatry position available at the Cape Cod & Islands Community Mental Health Center providing a continuum of psychiatric services through facility and community based care.

Highly competitive salary and benefits. On-call not required but available for additional income.

Please contact Susan Skea, M.D., Southeastern Area Medical Director at *Susan.Skea@ma.state.us* or Marcia Fowler at 617-877-0313.

MILLER SCHOOL OF MEDICINE UNIVERSITY OF MIAMI

Department of Psychiatry and Behavioral Sciences

The University of Miami (UM) Miller School of Medicine, Department of Psychiatry and Behavioral Sciences is in an exciting phase of **growth and expansion** with a new chairman, Julio Licinio, M.D.

We have Faculty opportunities at the Assistant/Associate Professor level in the following areas:

Mood Disorders
Psychotic Disorders
Emergency Services
Inpatient and Outpatient Services
Child & Adolescent Psychiatry
Consult/Liaison
Forensics

Find out more about our exciting opportunities at http://psychiatry.med.miami.edu.

Psychiatrists must possess two years or more experience in Psychiatric services. Duties include clinical evaluation and treatment of patients, teaching and supervision of medical students and psychiatry residents, and opportunities for participation in research and academic activities. Must be Board-Certified, Florida State license eligible and have suitable experience and credentials.

The University of Miami offers competitive compensation and excellent benefit packages, including college tuition remission for children.

Candidates should send cover letter, CV, and contact information for three recommendations to Dr. Ewald Horwath, Professor and Vice Chairman, Department of Psychiatry, University of Miami Miller School of Medicine, 1695 NW 9th Avenue, Suite 3100, Miami, FL 33136 or mgerdes@med.miami.edu.

The University of Miami is an Equal Opportunity/Affirmative Action Employer.

Connecticut DMHAS

Department of Mental Health and Addiction Services
A Healthcare Service Agency

The Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the area of mental health treatment and substance abuse prevention and treatment throughout Connecticut. We serve adults (over 18 years of age) with psychiatric or substance use disorders, or both, who lack the financial means to obtain such services on their own.

DMHAS has challenging opportunities for Staff Psychiatrists and Principal Psychiatrists to work with multi-disciplinary staff to provide a variety of behavioral health care services for adult individuals in collaboration with other State and community agencies. The State indemnifies employees for damage or injury, not wanton or willful, caused in the performance of his/her duties and within the scope of his/her employment as provided by Sections 4-165 and 19a-24 of the C.G.S. These positions provide excellent health/dental insurance and generous vacation/personal leave and licensure fee reimbursement. The requirements for these positions are as follows:

- **Staff Psychiatrist**-must possess and retain a license to practice medicine and surgery in Connecticut. Must be board certified as a specialist in psychiatry by the American Board of Psychiatry and Neurology within five years of appointment to this class OR demonstrate continued competency and proficiency in the practice of psychiatry by successfully completing an established agency program. Must possess and maintain eligibility for participation in federal health care programs as defined in 42 U.S. 1320a-7b (f).
- **Principal Psychiatrist**-must possess and retain a license to practice medicine and surgery in Connecticut. Must be board certified as a specialist in psychiatry by the American Board of Psychiatry and Neurology and may be required to possess and retain certification as a specialist in an area such as geriatrics, ABI/TBI, forensics, substance abuse, etc. Must possess and maintain eligibility for participation in federal health care programs as defined in 42 U.S. 1320a-7b(f).
- **Per Diem (Psychiatrist)**-must possess and maintain a license to practice medicine and surgery issued by the Connecticut Department of Public Health in accordance with the applicable CT General Statute. A temporary license may be granted for a period not to exceed one (1) year. Incumbents must have completed at least one year of residency program experience in psychiatry approved by the ACGME. Hourly Rate: $143.76

Positions are currently available at the following locations:

Western CT Mental Health System Network (full/part time positions) provides a variety of programs, including peer support programs, recovery services, supported employment, homeless services, residential, crisis services, jail diversion, outpatient, case management, Assertive Community Treatment Teams (ACTT) and young adult services in three state operated Mental Health Authorities located in Waterbury, Danbury and Torrington.

Capitol Region Mental Health Center (CRMHC) (full time position) located in Hartford, CT is a community-based mental health center which provides an array of innovative clinical and community support services to individuals with a psychiatric disability and in many cases with co-occurring problems of substance abuse.

Connecticut Valley Hospital (full/part time and per diem) is a 579 bed public psychiatric hospital located in Middletown, CT, has a multi-disciplinary staff to provide a variety of behavioral health care services (Geriatrics, Addiction Services and Forensics) for adult individuals in collaboration with other State and community agencies.

Individuals must complete a State Employment Application (PLD-1) AND DMHAS Addendum to the State Employment Application Form. Resumes and Curriculum Vitae can be provided as supplemental information but will only be accepted if attached to a fully completed Application and Addendum. Submit to: **Joan King, Human Resource Specialist, Human Resource Services Center - Employment Services Division, P. O. Box 1508, Middletown, CT 06457, FAX (860) 262-6770, Telephone: (860) 262-6782 (Ramonita Gonzalez), Email: Ramonita.Gonzalez@po.state.ct.us**

DMHAS is an Affirmative Action/Equal Opportunity Employer. Members of protected classes and/or individuals in recovery are encouraged to apply.

Minority Research Training in Psychiatry

Through its National Institute of Mental Health-funded Program for Minority Research Training in Psychiatry (PMRTP), the American Psychiatric Institute for Research and Education (APIRE) is seeking to increase the number of minority psychiatrists going into psychiatric research.

The program provides medical students and psychiatric residents with funding for stipends, travel expenses, and tuition for an elective or summer experience in a research environment. Stipends are also available for one- or two-year post-residency fellowships for minority psychiatrists. Deadlines for applications are December 1 for residents seeking a year or more of training and for post-residency fellows; or three months before training is to begin for medical students. Summer medical students who will start their training by June 30 should submit their applications by April 1.

Training takes place at research-oriented departments of psychiatry in major U.S. medical schools and other appropriate sites nationwide. An individual at the site (the research "mentor") oversees the research training experience.

The PMRTP is administered by the American Psychiatric Institute for Research and Education (APIRE). The director of the program is Darrel A. Regier, M.D., M.P.H.; the project manager is Ernesto A. Guerra. An advisory committee of senior researchers and minority psychiatrists developed guidelines for applicants and criteria for selection. The members of this committee evaluate and select trainees.

For more information,
Call: 1-800-852-1390 or 703-907-8622
E-mail: eguerra@psych.org
Write to PMRTP at the American Psychiatric Institute for Research and Education, 1000 Wilson Blvd, Ste. 1825
Arlington, VA 22209-3901

Bluegrass Regional Psychiatric Service, Inc. (Eastern State Hospital) is an adult psychiatric Hospital and has an immediate opening for a Psychiatrist. The hospital is a 180 bed facility and is located in Lexington, Kentucky. The hospital has award winning programming, including a treatment mall and a recovery based approach to treatment. The hospital provides inpatient services to over 50 counties in the central Kentucky area. Psychiatrists will lead a multidisciplinary treatment team for patient care with a case load of up to 15 inpatients.

Hours are flexible but generally M-F 8:00 am – 4:30 pm. Competitive salary plus outstanding fringe benefit package (including generous vacation, retirement and health/dental insurance) and sign on bonus.

Contact:

Mike Daniluk, Hospital Administrator
Bluegrass Regional Psychiatric Services
(Eastern State Hospital)
627 West Fourth Street, Lexington, KY 40508
Phone 859-246-7000; Fax 859-246-7018
e-mail mjdaniluk@bluegrass.org

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Top 100 Hospital recruiting top physicians and research scientists

Adult and Child and Adolescent Psychiatrists & Psychologists
Scott & White/Texas A&M College of Medicine
Temple and College Station Clinics

The Department of Psychiatry at Scott & White and Texas A&M College of Medicine is seeking outstanding candidates to join our nationally recognized Department of Psychiatry. Currently, we have openings for **Adult Psychiatrists** and **Child and Adolescent Psychologists** at our College Station Clinic. In addition, the department is seeking additional **Child and Adolescent Psychiatrists** for openings at our main facility in Temple. These positions will include clinical care, teaching of medical students and residents, and working within a group practice model. Candidates with solid clinical training, as well as interest and experience in behavioral medicine are preferred. Our department in Temple includes 12 full time Psychiatrists, 4 Psychologists and multiple allied health professionals providing clinical care to the majority of insured residents in Central Texas and the North Austin area. The division in College Station includes 2 full time Psychiatrists and 4 full-time Psychologists, offering a wide variety of preclinical and clinical teaching opportunities as the College of Medicine expands its campus in College Station. We are a full service Psychiatric Department with specialty clinics and programs. We have a diverse faculty with a close sense of collegiality.

Scott & White is the largest multi-specialty practice in Texas, with more than 530 physicians and research scientists who care for patients at Scott & White Memorial Hospital in Temple and within the 15 regional clinic system networked throughout Central Texas. The College Station clinic is the largest of the regional clinics, with more than 80 physicians from all specialties networked to the main campus and hospital in Temple. Over $250 million in expansions are currently underway, including two new hospitals and three regional clinics. Led by physicians with a commitment to patient care, education and research, Scott & White is listed among the "Top 100 Hospitals" in America and serves as the clinical educational site for The Texas A&M Health Science Center College of Medicine. Additionally, the 180,000-member Scott & White Health Plan is the #1 health plan in Texas.

Temple is centrally located less than 1 hour North of Austin, 2 hours South of Dallas, 3 hours West of Houston, and 2 hours North of San Antonio, making it an ideal place to live and/or commute to. College Station is 90 minutes west of Houston, 90 minutes east of Austin, and 3 hours south of Dallas, and is home to Texas A&M University. Scott & White offers a competitive salary and comprehensive benefit package, which begins with four weeks vacation, three weeks CME and a generous retirement plan. For additional information regarding these positions, please contact: **Jason Culp, Physician Recruiter, Scott & White Clinic, 2401 S. 31st, Temple, TX 76508. (800) 725-3627 jculp@swmail.sw.org** Scott & White is an equal opportunity employer. A formal application must be completed to be considered for these positions. For more information on Scott & White, please visit our web site at: www.sw.org

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Faculty Positions in Neuromodulation
Medical School, University of Minnesota

The University of Minnesota Medical School, its newly founded Institute of Translational Neuroscience, and its partner, University of Minnesota Physicians seek to hire faculty in the research area of Neuromodulation.

1) **Director of Neuromodulation:** The successful applicant will be a midcareer clinician investigator with rank and tenure status dependent on qualifications who can direct an integrated clinical neuromodulation program being developed by the departments of Neurology, Neurosurgery and Psychiatry in conjunction with the practice plan. Appointment is possible in any of the clinical neuroscience departments, i.e. Neurology, Neurosurgery, and Psychiatry, according to the individual's background and interests. The collaborating departments share a single administrative center. The successful applicant is expected to have clinical experience as well as an established research program that uses neuromodulation to treat diseases/disorders of the nervous system.

2) **Professor of Neuromodulation:** The successful applicant will be a physician-translational neuroscientist at the Assistant, Associate, or Full Professor level in the tenure track who is expected to have an established research program that uses neuromodulation to treat diseases/disorders of the nervous system. Appointment is possible in any of the clinical neuroscience departments and/or Department of Neuroscience.

3) **Professor and Director of Neuromodulation:** For an individual with the necessary interests and experience, combining the positions may be possible and appropriate.

For both positions, a record of ongoing extramural funding in the field is desirable. Areas of interest include but are not limited to degenerative diseases, movement disorders, dementia, depression, psychiatric disorders, developmental disorders, epilepsy, pain. These recruitments are supported by the practice plan, Medical School, and University's Institute of Translational Neuroscience. As one of the largest research universities in the country, the University of Minnesota offers a rich environment in basic, translational, and clinical neuroscience research, and a long tradition of collaborative interactions. The University of Minnesota in Minneapolis is located on an urban campus which overlooks the Mississippi River and which houses many colleges in addition to the Medical School and Academic Health Center. Starting date is negotiable.

Salary and start-up funds will be competitive and commensurate with education and experience. Candidates must have an M.D. degree or a combined M.D./Ph.D. degree and must be a U.S. citizen or be able to secure permanent residence status.

Applicants should send a current curriculum vitae, statement of research interests and intentions, and three letters of reference to:

Neuromodulation Search Committee
Attention: Walter C. Low, Ph.D., Chair, Search Committee
Department of Neurosurgery, University of Minnesota
2001 Sixth Street SE
Minneapolis, MN 55455 USA
or lowwalt@umn.edu

Electronic versions of the required information may be e-mailed but must be followed with a hard-copy for the official search files. Review of applications will continue until positions are filled.
The University of Minnesota is an equal opportunity educator and employer.

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1000 Wilson Blvd, Suite 1825
Arlington, Virginia 22209-3901

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Pamela Trujillo
Psychiatric News Classifieds
American Psychiatric Publishing Inc.
1000 Wilson Blvd, Suite 1825
Arlington, Virginia 22209-3901
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classads@psych.org

All advertising copy, changes and cancellations received after the deadline will be placed in the next available issue. We do not provide proofs of ads before publication.

DEADLINES: All new advertising copy, changes, and cancellations must be received *in writing* by Friday, 2 p.m. (E.T) two weeks prior to publication date. Publication dates are the first and third Fridays of every month. Specific deadline dates for upcoming issues are as follows:

Issue	Deadline (Friday, 2 p.m. E.T.)
December 21	December 7
January 4	December 19

The publisher reserves the right to accept or reject advertisements for Psychiatric News. All advertisers in this section must employ without regard for race, sex, age, nationality, or religion in accordance with the law. APA policy also prohibits discrimination based on sexual orientation or country of origin. Readers are urged to report any violations immediately to the executive editor.

Nationwide

Neuroleptic Malignant Syndrome Information Service presents the 4th *Annual NMSIS Promising New Investigators Travel Scholarship Program*. Residents, fellows and students are invited to submit a manuscript on psychotropic drug safety and side effects by Feb. 4, 2008. Prizes of $2500 and $1500 will be awarded at the American Psychiatric Association Meeting in Washington, DC, May 2008. Papers may be submitted to info@nmsis.org or faxed at (607) 674-7910. For more information, go to www.nmsis.org. Supported by an educational grant from Janssen, L.P., administered by Ortho-McNeil Janssen Scientific Affairs, LLC.

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MHM Services, Inc. is the nation's leading provider of correctional healthcare staffing. As one of the largest employers of mental health professionals in the nation, MHM Services is always looking for dedicated individuals who want a career that is both professionally rewarding and provides greater balance with less stress in their day to day life.

MHM Services is now offering Per Diem and traveling positions throughout the U.S. We offer competitive hourly rates, paid malpractice, paid travel expenses, direct deposit, and now company sponsored benefits for our Per Diem and traveling Psychiatrists.

Qualified candidates contact:

John Polich
800-729-1601 x5106
800-858-6305-Fax
jpolich@mhm-services.com
www.mhm-services.com

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Nationwide locum tenens assignments exclusively for Psychiatrists. We offer competitive pay and an ***APA*** endorsed Occurrence Malpractice Call Gene Itoh @ 800.735.8261 ext. 223, E-mail: gitoh@medsourceconsultants.com. Come browse our jobs at www.medsourceconsultants.com

ALABAMA

Mountain Lakes Behavioral Healthcare, located in beautiful northeast Alabama, has an excellent opportunity to practice general psychiatry in a community mental health center setting. We have an immediate full time opening in our Scottsboro Office in Jackson County (45 minutes from Huntsville). Looking for someone interested in a diversified caseload and varied work settings. Very good working conditions; eager, cooperative treatment team; competitive salary and benefits. Board certified or Board eligible. J-1; H1-B welcome. Contact: Greg Glasscock, email gglasscock@mlbhc.com; (256) 582-4240 ext. 107.

Excellent salary, full benefits, sunny Gulf Coast living, mostly outpatient practice with well-established group of 8 psychiatrists. Contact Jim Ault at St. John Associates, jault@stjohnjobs.com or 800-737-2001. Visit www.stjohnjobs.com for more opportunities nationwide.

ALASKA

Fairbanks Memorial Hospital in Fairbanks, AK, is looking for a full-time, adult, inpatient Psychiatrist to join our exceptional team. We have a 20-bed inpatient unit, staffed with a Nurse Director, RNs, an LPN, CNAs, Psych Techs, Counselors, an OT, Social Workers and a Medical Director.

FMH is committed to continually upgrading the level of care in our close-knit community and invite you to join us. Come experience the Alaskan way of life, full of adventure and beauty, and work at a top-notch facility.

For more information, call 888.303.5402 or e-mail Suzan.Bast@bannerhealth.com. Check out our Web site at www.fmhdc.com.

ANCHORAGE: Child or General Psychiatrist. Inpatient & residential treatment center. Join a great staff & physician team. Outstanding compensation potential - salary, benefits & bonus. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

ARIZONA

Assistant or Associate Professor, Clinical Psychiatry
or Professor, Clinical Psychiatry
University of Arizona (UPH Hospital-Kino)

The University of Arizona's Department of Psychiatry is recruiting adult psychiatrists to join a progressive and growing academic department located in the beautiful southwest with academic appointments as Assistant or Associate Professor, Clinical Psychiatry, or Professor, Clinical Psychiatry, depending on applicant's qualifications. Individual must be board-certified or -eligible in Psychiatry and have current credentials to practice medicine in the United States. Incumbent will provide clinical care in an inpatient facility with adult and geriatric populations. Other duties may include supervising and teaching adult psychiatry residents and medical students. Competitive salary and excellent benefits package offered. For more complete information about the positions, and to apply, go to **http://www.uacareertrack.com** and reference job **#36355**. If you have questions, please contact **Alesia Gillis, Human Resources, Dept. of Psychiatry, 1501 N. Campbell Avenue, P.O. Box 245002, Tucson, AZ 85724-5002; (520) 626-3819 or agillis@email.arizona.edu** . Review of applications is ongoing until positions are filled.

The University of Arizona is an EEO/AA Employer-M/W/D/V.

CALIFORNIA

County of Marin
STAFF PSYCHIATRIST
*$175,071/Annual *5% Assign Diff paid for Bil Span/Engl language. 1 f/t vacancy in Commty Mental Health Svcs - Adult. **Open and Continuous / Open Until Filled.** Online: www.co.marin.ca.us/Jobs. HR (415) 499-6104. AA/EOE.

Faculty Positions - UCSD

The Dept. of Psychiatry at the University of California, San Diego, is currently recruiting for contracted positions at the assistant or associate clinical professor level. We are seeking board-certified or board-eligible psychiatrists with a California medical license to practice in our community outpatient clinics. Preference will be given to candidates with a strong track record in clinical care, teaching experience and an interest or experience in clinical research. The positions offer flexible scheduling, along with potential teaching and research opportunities. The appointment level will be determined by the candidate's qualifications, and the salary is based on UC staff psychiatrist pay scales. Applicants should send their curriculum vitae and other supporting documents to: Attn: Dr. Lohr and Dr. Soliman, Search Committee K, UCSD Dept. of Psychiatry, 9500 Gilman Drive, La Jolla, CA 92093-0603. UCSD is an equal-opportunity employer.

Central California Psychiatric group looking for Board eligible/ Board certified psychiatrist to join a mature practice, with an enjoyable lifestyle, in a great setting, with in a short drive to mountains (Yosemite and Sequoia), coast and San Francisco. Practice consists of inpatient, outpatient and/or mixed schedule. Group primary orientation is psychopharmacology. Appointment with UCSF local program available. Competitive salary and benefits with ample opportunity to increase income.

Please send curriculum vitae and inquiries to:
Mateo F. De Soto, M.D.
E-mail: bbmc@bbmc-inc.com
Fax: (559) 437-1118
Mailing address:
1060 W. Sierra Ave., Ste 105
Fresno, CA 93711

UCSF DEPARTMENT OF PSYCHIATRY
SAN FRANCISCO GENERAL HOSPITAL

Due to expanding programs, the Department of Psychiatry of the School of Medicine, University of California, San Francisco (UCSF) seeks psychiatrists to serve as clinician-teachers at San Francisco General Hospital, a major teaching hospital of UCSF. The clinician-teacher role offers the opportunity to teach UCSF residents, medical students, and other trainees; to provide clinical leadership for multidisciplinary staff at the unit or team level; and to develop a defined area of scholarship and/or clinical research. The inpatient service features the award-winning Ethnic/Minority Psychiatric Inpatient Programs. Other services include the Psychiatric Emergency Service, community case management programs, and the Divisions of Psychosocial Medicine; Substance Abuse and Addiction Medicine; and Infants, Children, and Adolescent Services. Ideal candidates would be ABPN Board-certified or Board-eligible psychiatrists with inpatient and/or outpatient experience, a commitment to an academic career as a clinician-teacher, and demonstrated interest in working with underserved and culturally diverse populations in a public setting. Bilingual and/or bicultural abilities are desirable.

- Compensation: $154,000-$200,000 + dependent on qualifications and experience
- Relocation package
- Outstanding benefits package

Interested applicants should send or fax ([415] 206-8942) their resume and names and addresses/telephone numbers of three references to: Susan Brekhus, UCSF Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110. For additional information, you are welcome to call or email Susan Brekhus at (415) 206-3805 or email susan.brekhus@sfdph.org, Francis Lu, MD, Professor of Clinical Psychiatry at (415) 206-8984 or francis.lu@sfdph.org.

UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. UCSF is an affirmative Action/equal opportunity employer. All qualified applicants are encouraged to apply, including minorities and women.

Stanford University, Vaden Health Center
Director of Counseling and Psychological Services

Stanford University, a private research and teaching institution with 14,000 undergraduate and graduate students, seeks an experienced psychiatric leader for the position of Director of Counseling and Psychological Services, the mental health unit of Vaden Health Center within the Division of the Vice Provost for Student Affairs. The successful candidate will direct a comprehensive, professional mental health services unit and serve as a leading mental health expert and resource to the Stanford University campus community. The Director will have the opportunity to advance the fund of knowledge in college mental health through collaborative research with colleagues in Vaden Health Center, Stanford University and the mental health field.

Counseling and Psychological Services (CAPS) is fully accredited by the International Association of Counseling Services and supports the University's academic mission by providing comprehensive mental health services and programs to a diverse student body.

CAPS services are provided by an experienced multidisciplinary professional staff of psychiatrists, psychologists and social workers, who also supervise the work of Stanford University School of Medicine psychiatric residents and pre- and post- doctoral psychology trainees.

Reporting to the Director of Vaden Health Center, the Director of CAPS provides vision, leadership and supervision of all clinical, consultative, and mental health promotion programs. The Director of CAPS is appointed as a Clinician/Educator in the Department of Psychiatry and Behavioral Sciences, School of Medicine of Stanford University with academic rank commensurate with the level of the candidate's experience.

The Director of CAPS will play a central role in the realization of Vaden Health Center's commitment to the delivery of integrated psychological, medical and preventive care in order to promote and maintain the physical and emotional health and well-being of Stanford University students.

The Director of CAPS oversees clinical service delivery; program development and management; supervision of all professional staff; and determines and assures the provision of all appropriate evidence-based psychiatric and psychological treatment in compliance with prevailing current standards of care.

In addition to overall departmental leadership, the Director provides some direct psychiatric care to students and supervises the training of psychiatry residents and other mental health trainees at CAPS.

The Director works collaboratively with colleagues in: Vaden Health Center (including Medical Services and Health Promotion Services); Student Affairs and other student service related campus units; and the Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine. Using a population-based perspective, the Director provides leadership to formulate and implement programs and services to improve student mental health and well-being and enhance the supportiveness of the campus culture and university environment.

Qualifications: MD with Board Certification in Psychiatry is required, with a minimum of 10 years relevant experience. The CAPS Director must have strong leadership and management skills; experience in the creation of interdisciplinary coalitions to design and implement innovative clinical services and programs; strong verbal and written communication skills and a proven ability to interact effectively with diverse faculty, university staff, students and parents. Experience in college mental health in a comparable university setting is highly desirable.

To apply: Please submit a CV with an accompanying cover letter to CAPS Director Search Committee, c/o Amy Baldwin, Associate Director, Vaden Health Center, 866 Campus Drive, Stanford. CA 94305-8580. For additional information, phone (650) 725-1366 or email abaldwin@stanford.edu

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SAN FRANCISCO STATE UNIVERSITY,
STUDENT HEALTH SERVICES
PSYCHIATRIST
Part-time/Hourly; $55 - $91 hr.
Tuesday and/or Friday: 8 a.m. - 5 p.m.

The SFSU Student Health Services http://www.sfsu.edu/~shs/ is seeking an additional, part-time, Staff Psychiatrist (job#1156).

Join SFSU Student Health Services as we expand our services to meet the increasing demand in this diverse and dynamic population of 30,000 students. Work closely with a collegial primary care provider team and an enthusiastic staff.

This position is a one year temporary appointment with a strong likelihood of being extended.

Please contact Juliet Olson juliet_@sfsu.edu for a more detailed position description and advice on how to begin the application process!

https://cmsweb.sfsu.edu/psp/HSFPRDF/EMPLOYEE/HRMS/c/HRS_HRAM.HRS_CE.GBL. San Francisco State University is an equal opportunity employer.
This position is OPEN until filled.

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Attending Psychiatrists
Modesto, CA

Horizon Health, the nation's leader in Psychiatric Contract Management has opportunities for Attending Psychiatrists at a **70-bed**, free standing psychiatric facility in **Modesto, CA**. Easy access to the **San Francisco Bay** area, **Napa Valley** wine country, and **Yosemite National Park**. Employment available through local group of Psychiatrists via income guarantee or salary plus benefits. Relocation available. ADC of 40-70, ALOS 5-8 days, Call 1:4. Contact: Mark Blakeney, Horizon Health, 972-420-7473, fax CV: 972-420-8233, or email mark.blakeney@horizonhealth.com. EOE.

GREATER BAY AREA - Modesto, California

General & Child Psychiatrists needed, for unique, stable County Mental Health system in a welcoming community. Serve both public & private sector patients, in both inpatient/outpatient settings that have been benchmarked for their quality. Possibilities for Resident teaching & consultation with a full range of providers. When patients require hospitalization, inpatient & outpatient staff work **TOGETHER** to optimize care. Stanislaus County is located only 1 1/2 hours from both San Francisco and Yosemite, enjoying the best of both worlds.

Excellent salary scale, with steps from $159K to $194K; **PLUS** full benefits; **PLUS** 5% additional for each of following: Inpatient, General Boards, Child Boards; **PLUS** extra for limited On-Call; **PLUS** Union-negotiated increases already set for next few years. Negotiable hourly contract also an option. Fax CV to Marshall Lewis, MD, 209-558-8641 or call 209-558-4639.

BAY AREA DOCTORS INC. BE/BC psychiatrists for CA facilities. **UP TO $260 AN HOUR**. Earn up to $43,600 a month, working 4 ten hr days a week with no call. Flexible schedules, weekends possible. Extra for on call. Fax CV to 415-814-5764. Tel 707-694-6890. Email bayareadoctors@sbcglobal.net

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Assoc. Medical Director Position/Northern CA - the Beautiful Northwest - An incredible inpatient/outpatient opportunity (salaried or practice opportunity) awaits you. If you love the beauty of northern CA but want an area where the cost of living in CA is lower and the opportunity for a very lucrative practice is much higher, then consider this. Live and work in a culture-rich college town away from all of the professional and personal hassles of large city life only minutes from the gorgeous Sierra foothills and only an hour and a half from Napa Valley and Sacramento. Also an easy drive to the Bay Area, Lake Tahoe, and Reno. Please **call Terry B. Good, Horizon Health, at 1-866-865-7380**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com. Or mail CV to: 1663 Denton Lane, Hayes, VA 23072.

PSYCHIATRISTS

San Francisco Bay Area - Alameda County Behavioral Health Care Services - offers a full range of accessible mental health, alcohol and drug services to clients throughout all parts of the County. We are actively recruiting for full-time, part-time and services-as-needed Psychiatrists to provide psychiatric evaluation and treatment to adults in the Outpatient Services and Criminal Justice Mental Health Program.

Our network of services currently consists of over 400 individual practitioners, more than 90 community-based agencies, 20 hospitals and other institutions. Clients and their family members can now find geographically accessible services throughout all parts of the County. Services are available in all languages and are provided by a multicultural and multidisciplinary panel of service providers, many of whom have developed specialties that meet the often unique needs of our clientele. For more information, please visit: www.acbhcs.org

Physician III (Psych Option) $69.19-$84.01/hr.
Physician III SAN (Psych Option) $90.71/hr.
Additional Compensation to Base Salary:
5% Board Eligibility/Certification; 5% Lead Psychiatrist; 25% Criminal Justice

Min Req: Possession of a valid license to practice medicine in CA & completion of residency in psychiatry.

We offer highly competitive salaries and an extensive benefit package. Please contact Karl D. Adler, MD via his assistant Bernie Mullen at BMullen@acbhcs.org or (510) 567-8106, and apply on-line at www.acgov.org

Mental health consumers and bilingual applicants are strongly encouraged to apply
EOE

Central California Opportunity of a Lifetime!

Live in "the jewel" of Central California with a growing population of over 100,000 and enjoy an abundance of cultural and recreational activities along with affordable housing. This is an inpatient adult psychiatrist position in a hospitalist model at a 68-bed behavioral health facility. Work with a team of therapists, social workers, and nurses in providing consultation, pharmacotherapy, and psychotherapy to inpatients with diverse cases. The call coverage is one weekday night per week and one weekend in every four. This is truly an opportunity of a lifetime! Call 1-888-229-9495 for more information. **Send your CV to Tina Wilkins wilkinstina@earthlink.net or fax it to 916-536-9281.**

COLORADO

Adult or Child Psychiatrist
Denver

Kaiser Permanente Colorado seeks a full-time BC/BE Adult Psychiatrist or Child and Adolescent Psychiatrist to join our multi-specialty integrated healthcare organization and work in an outpatient staff model in collaboration with non-physician mental heath professionals who offer support and consultation to our colleagues in primary care. Colorado Permanente Medical Group is a physician-lead group providing services for the non-profit Kaiser Foundation Health plan; Colorado's most experienced Integrated Health care system. We offer a stable practice environment, competitive compensation, generous benefits/pension plan and reasonable call. Enjoy one of the best practice and lifestyle opportunities in the nation! Please contact Chantal Papez: 303-344-7302, or e-mail your CV to: Chantal.papez@kp.org. EOE, M/F, V/H. Website: http://physiciancareers.kp.org

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Medical Director
J-1 Visa Waiver Available

Horizon Health, the nation's leader in Psychiatric Contract Management seeks a **Medical Director** for a new **10-bed Gero-psych** unit at **Colorado Plains Medical Center**, a 50-bed acute-care hospital located in Fort Morgan, CO, serving a two-county area of 35,000. The hospital is fully accredited by JCAHO, and has a Level III Trauma Center, a 24-hour Emergency Room and many other services including diagnostic imaging services such as MRI, Nuclear Medicine, CT, Radiography, ACR-certified Mammography and Ultrasound. Rehab services include Physical, Occupational and Speech Therapies. Other services include Cardiopulmonary, Surgery, complete Lab Services, Obstetrics, Social Services, Dietary and Home Health.

Fort Morgan is big enough to have it all, and small enough to be a delightful home town. Fort Morgan has been thriving on the eastern plains of Colorado since it was established in 1884. The city now serves as the commercial and retail hub for all of Northeastern Colorado, and continues to grow into the 21st Century. Fort Morgan is located only 80 miles northeast of Denver on U.S. Interstate 76 and U.S. Highway 34, less than an hour's drive to Denver International Airport.

Attractive salary and benefits accompany this exciting new opportunity. **J-1 Visa waiver available**. Contact: Mark Blakeney, Horizon Health, 972-420-7473, fax CV: 972-420-8233, or email mark.blakeney@horizonhealth.com. EOE.

CONNECTICUT

INCREDIBLE GEROPSYCHIATRY PRACTICE OPPORTUNITY in an area nationally known as one of the MOST BEAUTIFUL residential communities in America! Located in the picturesque northwest corner of Connecticut, Sharon is an area with a great need for more psychiatrists. If being your own boss and the freedom of private practice is of interest, this is the perfect place to get established. Or if you have an outpatient practice already in the surrounding area, adding inpatient work on our unit could be a very lucrative addition to your current income. Exceptional prep schools, parks, and recreation. Contact Terry B. Good at Horizon Health, 866-865-7380; Fax: 804-684-5663; E-mail: terry.good@horizonhealth.cm. EOE

Director of Psychiatry

Masonicare is the leading not-for-profit provider of healthcare and retirement living in CT. and currently has an opening in our Trilogy Psychiatric Services practice for a **Director of Psychiatry** to work at our Masonic Healthcare Center, nationally recognized as a leader in Geriatric Care. Benefits for the opportunity to join a progressive not-for-profit leader include:

- **State-of-the-art facility and supportive work environment**
- **Strong academic ties to the University of Connecticut School of Medicine**
- **Concentrate on patient care in a serene setting**
- **Beautiful, inviting central Connecticut facility**

As the Director of Psychiatry, you will oversee the clinical management of all patients admitted to the inpatient psychiatric unit, LTC consultations and outpatient encounters. Some of the responsibilities include assuming clinical coverage for patients admitted to the unit; monitoring the quality and appropriateness of care and supporting the analysis of hospital accountability, service delivery and patient outcomes; acting as spokesperson for the department with outside agencies; and participating in program development. Additionally, the Director will be responsible for directing the total delivery of psych services, working with the Director of Outpatient Psychiatry, and other members of the multidisciplinary treatment team, to promote medical, spiritual and emotional care, encompassing quality, dignity, compassion and confidentiality for each individual.

In order to qualify for this position you must be a licensed M.D. by the state of Connecticut, and have at least two years' experience in psychiatry. Must be Board eligible or Board certified in Adult and/or Geriatric Psychiatry. Clinical expertise in inpatient psychiatry, ability to interpret and apply JACHO standards and State Public Health Code; strong communication skills with families and referral sources; and strong psycho-pharmacology management skills are all essential.

Masonicare provides a competitive salary with a comprehensive benefits package. For immediate consideration, please send your resume in confidence to Masonicare, Attn: Sarah Dorsey, Recruitment Manager, 22 Masonic Avenue, P.O. Box 70, Wallingford, CT 06492. Fax: 203-679-6858. Email: careers@masonicare.org Visit our website at: www.masonicare.org Masonicare is an equal opportunity employer.

DELAWARE

Mental Health-Psychiatrist Child/Adol (BC/BE) to provide evaluations, Medication therapy and consult with staff in a highly regarded, private, not-for-profit child guidance clinic in Dover, DE.
Full-time. No weekends. Competitive package. Send cover letter and resume to: Delaware Guidance Services, HR, 1213 Delaware Ave., Wilmington, DE 19806. Fax: 302-652-8297
EOE.

DOVER: General Psychiatrist - Inpatient & Partial programs. Staff position. Offering base salary, benefits and more... Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

FLORIDA

DAYTONA - MELBOURNE - ORLANDO - MIAMI - FORT LAUDERDALE - PALM BEACH - OCALA - GAINESVILLE - FORT MYERS - SARASOTA - PENSECOLA - JACKSONVILLE - Psychiatrists needed for rapidly expanding Nursing Home Service. Great support. No call. Average Salary 210K + benefits. Part-time available. Some travel required. Must have FL Medicare & FL Medicaid individual provider #s. No Restrictions (H1B Candidates Considered). Call our administrator, Christy, at 866-936-5250.

Psychiatrist Opportunities

Mental Health Resource Center, Inc. (MHRC) currently has two Psychiatrist positions available in Jacksonville: one Psychiatrist is needed for its Adult Florida Assertive Community Treatment (FACT) Program; and one Psychiatrist is needed to provide outpatient and inpatient psychiatric services (the inpatient services will be provided at Shands Jacksonville Medical Center). Both are full-time salaried positions with a comprehensive benefits package. Florida licensure and Board Eligibility/Certification required. MHRC is a JCAHO accredited comprehensive community mental health center. To apply, contact Dr. Robert Sommers, President/CEO, MHRC/RBHS, P.O. Box 19249, Jacksonville, FL 32245. e-mail: rbhspres@bellsouth.net. Fax: (904) 743-5109. Phone: (904) 743-1883, ext. 219.

Psychiatry busy solo practice for sale in South Florida Prime Location. Fee for service, no insurance with great expansion potential. Fax inquiries to: 561-482-9582.

Psychiatrists

Lee Mental Health Center, Inc. (LMH) is seeking PT and FT Psychiatrists to provide high quality treatment to adults in our (inpatient) Crisis Stabilization Unit and Outpatient Medical Services departments.
LMH is a private, non-profit agency and the primary mental health agency for Lee County in Southwest Florida. We offer a continuum of mental health and substance abuse services for adults and children.
LMH is located on the vibrant Gulf Coast of Florida. Lee and its neighboring counties offer a variety of residential communities with excellent public & private schools/colleges/universities. Residents enjoy a wide array of recreational and cultural activities. You are encouraged to experience the diversity and beauty of Southwest Florida!
Position salary range is $145,000 - $155,000 per year (for FT), plus additional opportunities for income via rotating inpatient on-call duty and rounds. Comprehensive benefits for FT employees include health/dental/life; flexible spending account (health care); short and long term disability (& other supplemental insurance options); malpractice; generous paid time off & paid holiday plan; 403b retirement plan with employer contributions...and more.
Please submit CV to: Marianne Krouk, D.O., Chief Medical Officer, 2789 Ortiz Avenue, Fort Myers, FL 33905; or fax: 239-418-0094; or e-mail: resume@leementalhealth.org. For additional information please visit www.leementalhealth.org
EOE/DFWP

New Port Richey - Fantastic Practice Opportunity in a Coastal Location - If being your own boss and having the freedom to set your own work schedule is what you've wanted, then please call me. This is an opportunity to open an inpatient and outpatient private practice (adult and geriatric) in the fifth fastest growing county in FL. Or if you have a practice already, adding our inpatient component to your income could be extremely lucrative. Call is 1 in 4. Please **call Terry B. Good at 1-866-865-7380**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com. Or mail CV to: 1663 Denton Lane, Hayes, VA 23072.

GEORGIA

Quiet Country Setting close to large metro area in Beautiful NW GA. Community Mental Health Opportunity for BC/BE Psychiatrist. FT/PT Adult and C&A opportunities available. We offer excellent benefits and competitive salary. Opportunities for employment are available in our crisis unit and clinics. Agency serves Whitfield, Polk, Floyd, Bartow, Gilmer and Fannin Counties. Extra call available if desired. Send CV to our HR Dept. at jobs@highlandrivers.org or fax 706-270-5129.

ATLANTA: Staff Psychiatrist to work with adolescents & adults with psychiatric & substance abuse issues. Inpatient & partial programs. Salary & benefits offered. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

IDAHO

Eastern Idaho Regional Medical Center Behavioral Health Center

The Behavioral Health Center of Eastern Idaho Regional Medical Center has two different exceptional opportunities with a very competitive compensation for qualified psychiatrists. Idaho Falls is a very livable and affordable city and is located in a marvelous area, less than two hour drive from Jackson Hole, Yellowstone National Park, and the Grand Tetons. Idaho Falls is a community of 60,000+ people and the Behavioral Health Center serves a market area of over 300,000 people. The Behavioral Health Center is a 76 bed free standing psychiatric hospital with 30 residential treatment beds and 46 acute care beds. BHC is located two blocks from the medical center and has direct access to all of the relevant medical services.

The practice opportunities which are available for a board certified or board eligible child psychiatrist include the following primary options:

1. An affiliation with the hospital with an income guarantee, sign-on bonus and an executive relocation package to help a physician establish their private practice. There are opportunities to enter a practice association with one of the other psychiatric practices or counseling groups in the community.
2. A full time employment arrangement which would include inpatient and outpatient work.

Currently the Behavioral Health Center has 4 full time affiliated psychiatrists and 1 psychiatrist who cover one weekend of call every month. Until the recruitment is complete, locum tenens coverage will be continued. With the addition of the new psychiatrists we anticipate an average weekday call of 1 in 6 and a weekend call that would average 1 in 10.

If you would like to learn more about this tremendous opportunity, please contact me at your earliest convenience.

Regards,

Eric Mack, Market Manager
HCA Physician Services
Office: (949) 366-4154
Cell: (714) 404-9683
Fax: (866) 824-9444
www.hcahealthcare.com

ILLINOIS

Join an outpatient practice located in the Bloomington-Normal area midway between Chicago and St. Louis. Practice offers great flexibility and includes two psychiatrists and a therapist. Friendly college and residential community provide excellent location to raise a family and potential for further growth. Contact Dr. Raju Paturi 309/862-0064 and Fax CV with photo 309/862-1542.

Minutes from downtown CHICAGO!!! Well established hospital has 4 exciting needs! 1. ADULT - Mix of inpatient and outpatient work 2. C&A - Mix of inpatient and outpatient 3. ADDICTIONS - Mix of outpatient and partial hospital work. 4. EATING DISORDERS - exclusively eating disorder patients. Salary is HIGHLY COMPETITIVE with full benefits package and BONUS incentives! For more info, contact Carrley Ward at 800-735-8261 x 219, fax your CV to 703-995-0647 or email cward@medsourceconsultants.com

INDIANA

University town, short trip to Indianapolis! Adult and Child & Adolescent psychiatrist needed for OUTPATIENT work. Light to NO CALL! Competitive salary, full benefits, bonus incentives available, and relocation offered! H1-B visa holders welcome! For more information on this opportunity or any of other nationwide opportunities, please contact Ariana Sanjabi @ 800.735.8261 ext.214, fax your CV to 703.378.0016 or e-mail: asanjabi@medsourceconsultants.com.

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90 minutes to downtown Chicago. Join very stable practice with 10 psychiatrists in a renowned university community. Contact Jim Ault at St. John Associates, jault@stjohnjobs.com or 800-737-2001. Visit www.stjohnjobs.com for more opportunities nationwide.

Psychiatrists wanted

Midtown Community Mental Health Center, Indianapolis, IN is seeking several BC/BE Psychiatrists. Seeking one (1) outpatient psychiatrist to work with ACT Team as well as provide care for patients with SMI. Seeking one (1) psychiatrist to work in our Adult Outpatient services.

Need to be licensed to practice medicine in the state of Indiana. J-1 Visa applicants are welcome. Comparable salary and benefits package plus paid malpractice insurance.

Send CV to Steve Fekete, M.D., Medical Director, Midtown CMHC, 850 N. Meridian St., Indianapolis, IN 46204 or FAX: 317-554-2721. Telephone: 317-554-2703 or Email: deborah.hall@wishard.edu.

KANSAS

The University of Kansas School of Medicine-Wichita Position Announcement

Department of Psychiatry and Behavioral Sciences

Exciting faculty opportunities exist due to growth and expansion of the department. Positions available in child and adolescent psychiatry, residency leadership, community psychiatry, consultation and liaison, and clinical instruction.

KUSM-W is an equal opportunity employer.

Contact:
Dr. Russell Scheffer, Chair
KUSM-W
1010 North Kansas
Wichita KS 67214
rscheffer@kumc.edu
316-293-2669

KENTUCKY

Adult inpatient Psychiatric facility located in western Kentucky has an immediate opening for a full time licensed psychiatrist (BE/BC). Must be licensed in State of KY prior to employment. Fax C.V. to Director of Administrative Services at 270-886-4487. EOE M/F/D/V

LOUISIANA

The Louisiana Office of Mental Health is seeking psychiatrists to work across the state in a variety of positions. We have a unique mental health care delivery system that is transforming itself in a number of ways to better meet the needs of our citizens. With the challenges we are facing from the 2005 hurricane season, our system has had to be creative and responsive. Come be a part of the recovery of our beautiful state! Positions are available in urban and rural areas, inpatient and outpatient facilities, and forensic and civil settings; adult and child psychiatrists are needed. For more information, please contact Kathleen Crapanzano, M.D., Office of Mental Health Medical Director, 628 PO Box 4049, Baton Rouge, LA 70821-4049 or phone at 225-342-2550 or e-mail at kcrapanz@dhh.la.gov.

Ochsner Health System

BC/BE Psychiatrist

OCHSNER ST. ANNE GENERAL HOSPITAL is seeking:

- A BC/BE Psychiatrist for an employed position in Raceland, Louisiana
- Located 40 miles from New Orleans with a population of approximately 40,000
- Not-for-profit critical access hospital providing inpatient & outpatient services with high quality, cost-effective emergency, medical & surgical care
- Part of nationally renowned health system of 7 hospitals, 600+ member physician group, and 28 health centers
- Very competitive salary and benefits
- Family-oriented community with year-round outdoor activities
- Favorable malpractice environment in Louisiana
- J-1 visa candidates are welcome to apply
- Ochsner Health System is an equal opportunity employer.

Please email CVs to: profrecruiting@ochsner.org or call (800) 488-2240.
Ref# APSYN4.

DEPARTMENT OF PSYCHIATRY AND NEUROLOGY, TULANE UNIVERSITY SCHOOL OF MEDICINE in New Orleans, LA, is recruiting for several general and forensic psychiatrists (clinical track) for our growing department, at the Assistant/Associate Professor level. Candidates must have completed an approved general psychiatry residency and be board certified/eligible in general psychiatry and forensic psychiatry, respectively. Responsibilities will include direct patient care, teaching of medical students and house officers (including those in our accredited forensic psychiatry fellowship program), and research (clinical and basic science) at various state hospitals, state correctional institutions, and at Tulane University Health Sciences Center. Time allocations will be based upon individual situations. Applicants must be eligible to obtain a Louisiana medical license. Applications will be accepted until suitable qualified candidates are found. Send CV and list of references to John W. Thompson, Jr., M.D., Vice Chair, Adult Psychiatry and Director, Division of Forensic Neuropsychiatry, Tulane University School of Medicine, Department of Psychiatry and Neurology, 1440 Canal Street TB53, New Orleans, LA 70112. For further information onsite, please contact Dan Winstead, MD, Chair of Psychiatry and Neurology, at 504-473-5246 or winstead@tulane.edu. Tulane is strongly committed to policies of nondiscrimination and affirmative action in student admission and in employment.

Crossroads Regional Hospital
Alexandria, Louisiana
J-1 waiver available

Our hospital is seeking psychiatrists to apply for immediate openings.
Full time employment
- Salary $175,000/yr + Bonus
(or)
To establish full time practice
- Hospital guarantees net annual income of $200,000
- Additional income belongs to practitioner
- Hospital will lend funds to start practice and other expenses.

The hospital is a 70-bed freestanding psychiatric hospital, providing adult, adolescent and geriatric inpatient services. The hospital also has partial day program and intensive outpatient programs.
Alexandria is the biggest city in central Louisiana, located on interstate 49 and within driving distance to Lafayette, Baton Rouge and Dallas.

Please apply with CV to:
P. Nelakurthi,
Bayou Health Care, LLC.,
5425 Brittany Dr, Suite A,
Baton Rouge, LA 70808
or fax: 225-766-6400
or email to: hradmin@crossroadshospital.org

MAINE

Dartmouth Faculty Psychiatrists

Dartmouth Medical School, Department of Psychiatry, in collaboration with the State of Maine Department of Health and Human Services, seeks faculty psychiatrists for the Riverview Psychiatric Center in Augusta, Maine. The Center is the flagship inpatient hospital serving central and southern Maine's system of public mental health care. A 92-bed, state of the art, replacement hospital opened in the Spring of 2004. Preference will be given to candidates with forensic training and/or experience. Maine licensure required. These are full-time Dartmouth faculty appointments with salary and rank commensurate with experience and academic accomplishments. Protected time for scholarly activities. Central and southern Maine offers exceptional opportunities to enhance your quality of life. We have safe communities, with very low crime, good schools and unparalleled four season recreational activities. Augusta is less than one hour from the Maine coast and closer to numerous crystal clear lakes and mountains. It is no wonder Maine is called "vacationland." Please send CV and three letters of reference to: **Alan I. Green, MD, Professor and Chair of Psychiatry, Dartmouth Hitchcock Medical Center, One Medical Center Drive, Lebanon, NH 03756**. Dartmouth Medical School is an EOE/AA Employer and encourages applications from women and members of minority groups.

Child Psychiatrist - Waterville, Maine (No call & No weekends)
Our organization operates the largest Medication Clinic in the region, and we are looking for a Child Psychiatrist to join our team. BE/BC with Maine Medical License or immediate eligibility for licensure. Contact: Mike Walsh, Kennebec Behavioral Health: Telephone (207) 873-2136; Fax (207) 877-8427; e-mail mwalsh @kbhmaine.org.

Adult Psychiatrist - Waterville, Maine (No Call & No Weekend Coverage)
Our organization operates the largest Medication Clinic in the region, and we are looking for an Adult Psychiatrist to join our team. BE/BC with Maine Medical License or immediate eligibility for licensure. Apply to: Mike Walsh, Kennebec Behavioral Health: Telephone (207) 873-2136; Fax (207) 877-8427; e-mail mwalsh @kbhmaine.org.

FCS

THE 1ST CHOICE IN
PSYCHIATRIC RECRUITMENT
Mid-Coastal Maine
Adult Inpatient / Loan repayment
For more information contact:
YVONNE CHAMBERS
(800) 783-9152 FAX (270) 782-1055
www.fcspsy.com
admin@fcspsy.com

Maine's First Magnet Hospital and the World's First Free-Standing Psychiatric Magnet Hospital
Seeking Adult and Child/Adolescent Psychiatrists

We are seeking BC/BE psychiatrists for both our adult and child/adolescent inpatient and outpatient programs. Acadia Hospital is a thriving, non-profit, private community-based hospital offering acute psychiatric care for adults and children, as well as chemical dependency programs. One of the only two private psychiatric hospitals in Maine. The Acadia Hospital offers physicians clinical practice in a highly collaborative, multi-disciplinary setting. Competitive salary and benefit package. Send resume to: Vice President of Medical Affairs, The Acadia Hospital, P.O. Box 422, Bangor ME 04402-0422. EOE. **www.acadiahospital.org**

MARYLAND

FT Salaried Psychiatrist needed for private practice in Baltimore. Duties are rotating between inpatient geropsych, PHP/IOP, and general hospital C-L rotating every 4 months. Also, there will be several nursing homes assigned that will be ongoing throughout the year. Salary will be up to $191,000 per year with 2 weeks paid vacation the first year, simple IRA with 3% match, and a health care plan with an HSA account. Also there may be extra income holiday bonus and there is ownership opportunity after 2 years allowing additional profit sharing. Baltimore is an attractive area with sports, culture and nature. Great for families and has excellent schools. Call 410-825-2281 or email suite309@aol.com

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Clifton T. Perkins Hospital Center, a JCAHO-accredited institution and Maryland's only maximum security forensic hospital, is seeking candidates for the position of staff psychiatrist. Candidates with forensic interest or experience would be especially well-suited. Responsibilities include the provision of high quality psychiatric care on an inpatient unit in a state-of-the-art forensic facility. Additional opportunities include evaluations of dangerousness, competency to stand trial, and criminal responsibility.

Join a vibrant medical staff with expertise in care of the seriously mentally ill within a forensic setting. Faculty appointments are available at University of Maryland and Johns Hopkins Hospitals, if eligible. The hospital is centrally located 20 minutes from Baltimore, 35 minutes from DC, and 20 minutes from Annapolis. Competitive salary with excellent benefits, flexible working hours, and the opportunity for paid overnight call.

Interested candidates should contact Robert Wisner-Carlson, MD at 410-724-3078 or P.O. Box 1000, 8450 Dorsey run Road, Jessup, MD 20794 (wisnerr@dhmh.state.md.us.)

Faculty Position
Assistant Professor (Tenure Track)
Department of Psychiatry

The Department of Psychiatry at the Uniformed Services University of the Health Sciences, Bethesda, MD is seeking to fill an Assistant Professor, tenure-track, teaching and research position. The Department is comprised of twenty full-time faculty and has active research interests in the neurobiology and behavior of stress, PTSD, anxiety, depression, and substance abuse. The successful candidate will participate in and develop medical student and resident education, a research program and provide clinical care. Individuals who hold an M.D., have completed an approved psychiatric residency and are board eligible/certified are invited to apply. Send curriculum vitae, description of current and anticipated research interests and the names and addresses of four references to: Robert J. Ursano, M.D., Chairman, Department of Psychiatry, Uniformed Services University, 4301 Jones Bridge Road, Bethesda, MD 20814 (psychiatry @usuhs.mil). Review of applications is ongoing. The University is an affirmative action/equal opportunity employer.

Psychiatrist

Pathways, Inc., the longest operating multi-service mental health agency in St. Mary's County, located on Maryland's western shore of the Chesapeake Bay, is seeking a licensed; board certified/board eligible Psychiatrist for the position of Medical Director.

St. Mary's County has been designated as an underserved area for mental health professionals so applicants with foreign visas are welcome. Assistance with moving expenses and student loan payments consistent with the underserved area designation for this county are possible. Additional benefits include a competitive wage, medical, dental, disability, and malpractice insurance, paid leave and no on-call requirement.

This position will require a minimum effort of thirty-five (35) hours per week. Salary and other terms are negotiable. If interested please submit your C.V. and letter of interest to: **Jack Dent, Administrative Officer, Pathways, Inc., P.O. Box 129, Hollywood, MD 20636, 301- 373-3065 ext. 208, Fax 301-373-3265, e-mail: jdent@pathwaysinc.org**

Psychiatrist

Springfield Hospital Center - a 405 bed psychiatric in patient facility, operated by The Maryland State Mental Hygiene Administration seeks Maryland licensed Psychiatrists. Our rural 400 acre campus is located 22 miles west of Baltimore and convenient to Washington, DC. via routes 70 & 29. We offer full time and part time positions with comprehensive benefits, which include 27 days of paid leave, medical coverage and access to Maryland State Employees Pension at retirement. Additionally, Contractual day/night positions available. Both Board & Non-Board Certified physicians will be considered. Salary for these positions is negotiable. Please send CV to: Jonathan Book, M.D., Clinical Dir, SHC, 6655 Sykesville Rd. Sykesville, Maryland 21784. For questions call 410-970-7006 or email Jbook@dhmh.state.md.us. EOE

MASSACHUSETTS

SUPERVISORY PSYCHIATRIST

Opportunity for a Board-Certified/Board-Eligible Psychiatrist to join the expanding Mental Health Service at the Northampton VAMC. Experience or specialized training in geriatrics is highly desired, teaching, PTSD, supervisory experience and/or primary care psychiatry are a plus. This is a leadership position that includes supervision of psychiatrists and exciting program development opportunities to meet the needs of the new veteran population. Northampton is an active, diversified Medical Center, with 3 satellite outpatient clinics, a 16-bed substance abuse/compensated work therapy Psycho-social Residential Rehabilitation Treatment Program, 85 psychiatric inpatient beds, and 66 nursing home care unit beds. Specialized programs include PTSD, substance abuse, chronically mentally ill, and acute psychiatry. Opportunities are currently available for teaching residents as well as psychology and social work interns. Congenial work atmosphere, stimulating colleagues, and minimal night and weekend duties make this a very pleasant place to work. Northampton is located in the heart of the "five college" area of Western Massachusetts and abounds in cultural attractions. Two hours from Boston, three hours from Times Square, yet in its own cultural base, the area is ideal for raising a family. This Medical Center is affiliated to the Dartmouth Medical School. Competitive salary and federal benefits. EOE employer.
Send CV to: Michelle Zehelski, Human Resource Staffing Clerk (05-HR), Northampton VA Medical Center, Leeds, MA 01053, (413) 584-4040, ext. 2124; FAX (413) 582-3146.

STAFF PSYCHIATRIST

Opportunity for a Board-Certified/Board-Eligible Psychiatrist to join the expanding Mental Health Service at the Northampton VAMC. Experience or specialized training in geriatrics is highly desired, teaching, PTSD, and/or primary care psychiatry are a plus. Northampton is an active, diversified Medical Center, with 3 satellite outpatient clinics, a 16-bed substance abuse/compensated work therapy Psycho-social Residential Rehabilitation Treatment Program, 85 psychiatric inpatient beds, and 66 nursing home care unit beds. Specialized programs include PTSD, substance abuse, chronically mentally ill, and acute psychiatry. Opportunities are currently available for teaching residents as well as psychology and social work interns. Congenial work atmosphere, stimulating colleagues, and minimal night and weekend duties make this a very pleasant place to work. Northampton is located in the heart of the "five college" area of Western Massachusetts and abounds in cultural attractions. Two hours from Boston, three hours from Times Square, yet in its own cultural base, the area is ideal for raising a family. This Medical Center is affiliated with Dartmouth Medical School for education and research. Competitive salary and federal benefits. EOE employer.
Send CV to: Michelle Zehelski, Human Resource Staffing Clerk (05-HR), Northampton VA Medical Center, Leeds, MA 01053, (413) 584-4040, ext. 2124; FAX (413) 582-3146.

Outpatient and Inpatient Psychiatrists - VA Boston Healthcare System

The VA Boston Healthcare System is recruiting board certified (BC) or board eligible (BE) psychiatrists for outpatient and inpatient positions in Brockton and Boston. Outpatient/inpatient psychiatrists at our Brockton site and outpatient psychiatrists at our Boston sites will have important teaching roles in the Harvard South Shore and Boston University Psychiatry Residency Training programs. Experience and accomplishments will be commensurate with appointment as a faculty member at Boston University School of Medicine and/or Harvard Medical School. These positions offer a highly competitive VA salary and exist in an outstanding academic environment with prominent teaching and research programs. Recruitment bonus is available to qualified candidates. To apply, candidates should send a letter of interest, CV, and the names of three persons to contact for references to Joseph Felton (05D), Human Resources Specialist at VA Boston Healthcare System, Brockton Division; E-mail vhabhsjobs@med.va.gov and a copy to : Gary.Kaplan@med.va.gov For further information regarding the position, please contact Dr. Gary Kaplan, Director, Mental Health Service, VA Boston Healthcare System, 940 Belmont Street Brockton, MA 02301. Phone: 774-826-2486.

We are an Affirmative Action/Equal Opportunity Employer with a strong institutional commitment to diversity in all areas.

Massachusetts: MHM Services, Inc. is proud to announce our affiliation with the Massachusetts Department of Correction. Positions currently exist at MCI Shirley (PT 28hrs/wk) and NCCI/Gardner (PT 28hrs/wk). Hours may be combined to form a full-time position or may be divided to form a variety of part-time options. We are seeking Psychiatrists who are ready to make a difference to an underserved population while being part of an elite organization that offers outstanding benefits and generous compensation. Gain personal and professional satisfaction, while utilizing your skills in a safe and supportive work environment. Guide the delivery of mental health services to this diverse population of incarcerated individuals. Contact Holley Schwieterman at (866) 204-3920 or email: hschwieterman@mhm-services.com to learn more. www.mhm-services.com

EEO/AA

Child and/or Adult Psychiatrists BC/BE Child and/or Adult Psychiatrists needed at MSPCC

FT & PT opportunities available in New Bedford, Springfield and Holyoke, MA

MSPCC (Massachusetts Society for the Prevention of Cruelty to Children) is a private, nonprofit society with a legacy of strengthening families and preventing child abuse through essential child welfare and mental health treatment and effective public advocacy. In this role, you will evaluate the psychological, neurological, and psycho-pharmacological status of clients; provide ongoing medication follow-up of clients; and provide direct psychotherapy when indicated.

Please send CV to: **Email: recruitment@mspcc.org; OR Fax: 617.587.1586; OR Mail: Kim Wong and Dr. Sam Kelley, MSPCC, HR, 99 Summer St. 6th Floor, Boston, MA 02110.**

EOE

www.mspcc.org

The Berkshires~ Western Massachusetts

Child Psychiatrist
Berkshire Medical Center, in Pittsfield, MA, is currently seeking a BC/BE Child & Adolescent Psychiatrist, with interest in community mental health, for its integrated mental health and substance abuse treatment network. Academic appointment possible through teaching affiliation with UMASS Medical School. Competitive salary and benefits package, including relocation. The Berkshires is a 4-season resort community with endless cultural and recreational opportunities. Excellent public and private schools make this an ideal family location, just 2 ½ hours from both Boston and New York City. Please send CV, or contact: Alex Sabo, MD Phone: 413-447-2162, asabo@bhs1.org, Fax: 413-447-2041 www.berkshirehealthysystems.org

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CENTRAL MASSACHUSETTS - Child and Adolescent Psychiatrist/Medical Director Faculty Positions
The University of Massachusetts Medical School (UMMS), Department of Psychiatry, is seeking child psychiatrists to serve as Medical Directors at the UMass Intensive Residential Treatment Programs located at Westborough State Hospital and Worcester State Hospital, each serving adolescents ages 13-19 years. Length of stay of several months or more supports a milieu treatment program/team approach. Positions may be full or part-time (28 hours/week). Candidates must be BC/BE in Child and Adolescent Psychiatry. Experience in teaching and training residents and medical students is desirable. Faculty appointment, teaching, and research opportunities available. Competitive salary and excellent benefits. Join a vital and growing academic division of Child Psychiatry. Send letter of interest and C.V. to: W. Peter Metz, M.D., Director, Child & Adolescent Psychiatry, UMass Medical School, 55 Lake Avenue North, Worcester, MA 01655 or e-mail peter.metz@umassmed.edu AA/EOE

Boston North Shore: Northeast Hospital Corporation, a locally-based nonprofit medical and psychiatric system recently named one of the nation's top 100 integrated healthcare systems by Solucient, has opportunities for board certified or eligible psychiatrists at two of its facilities:

Beverly Hospital; inpatient or inpatient/C and L combination. Help take this general hospital psychiatry program to the next level! Two positions available, including Medical Director position for experienced psychiatrist with leadership skill; C/L fellowship training a plus. Salary is competitive with an excellent benefit package including generous time off and reimbursement for malpractice insurance and CME. Limited call, and lucrative coverage opportunities are available.

BayRidge Hospital: This well-established 62-bed psychiatric hospital located in Lynn, a teaching site for Boston University Medical School, has a full-time position for an inpatient psychiatrist. Work with an excellent and supportive staff in a friendly atmosphere. There is no required night call, but lucrative coverage opportunities are available. Salary is competitive with an excellent benefit package including generous time off, and reimbursement for malpractice insurance and CME.

Contact: Barry Ginsberg, M.D., Chief, Department of Psychiatry. Phone (781) 477-6965, Fax (781) 477-6967; email address: bginsber@nhs-healthlink.org

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The Berkshires~ Western Massachusetts

Adult Psychiatrist
Berkshire Medical Center, in Pittsfield, MA, is currently seeking a BC/BE Adult Psychiatrist, with interest in community mental health, for its integrated mental health and substance abuse treatment network. Academic appointment possible through teaching affiliation with UMASS Medical School. Competitive salary and benefits package, including relocation. The Berkshires is a 4-season resort community with endless cultural and recreational opportunities. Excellent public and private schools make this an ideal family location, just 2 ½ hours from both Boston and New York City. Please send CV, or contact: Alex Sabo, MD Phone: 413-447-2162, asabo@bhs1.org, Fax: 413-447-2041 www.berkshirehealthysystems.org

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Full-Time Psychiatrist to Serve Chronically Homeless Individuals in Boston
Unique opportunity for a dynamic and energetic psychiatrist to join an exciting new initiative to integrate psychiatric and medical care for homeless individuals in Boston. Position involves working with a multi-disciplinary team for Boston Health Care for the Homeless Program (BHCHP) and the Massachusetts Mental Health Center / Massachusetts Department of Mental Health. This model team will be responsible for caring for chronically homeless persons directly on the streets, in BHCHP's shelter clinics and hospital clinics at Massachusetts General Hospital and Boston Medical Center, and the Massachusetts Mental Health Center. Harvard academic appointment available. Excellent salary and benefits. Interested candidates should contact: Shawn Pickering Boston Health Care for the Homeless Program 729 Mass Ave Boston MA 02118 Fax: 857-654-1093 www.bhchp.org

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CAMBRIDGE: Inpatient Unit Director/ Attending Psychiatrist

Position available at Cambridge Health Alliance Department of Psychiatry, Harvard Medical School. Full time inpatient unit Medical Director with clinical responsibility for a 9 patient team on an 18-bed teaching service. Clinical care is provided through a multidisciplinary team approach with psychiatrist leadership. The inpatient medical director will also oversee provision of care on the unit, lead quality initiatives on the unit, oversee teaching of residents, medical students and psychology interns, and demonstrate commitment to clinical excellence.

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

Qualifications: Board-certified, 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. 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 Derri Shtasel, MD, Dept. of Psychiatry, 1493 Cambridge Street, Cambridge, MA 02139. Fax 617-665-2521. Email: DShtasel@challiance.org** (email preferred).

CAMBRIDGE Health Alliance: Women's Health

Position available at Cambridge Health Alliance Department of Psychiatry, Harvard Medical School. Part time opportunity in Women's Health/outpatient C/L Psychiatry. The Department of Psychiatry at Cambridge Health Alliance is an appointing department at Harvard Medical School. Our public health commitment to improving the health of our communities, coupled with a strong academic tradition, make this an ideal opportunity for candidates interested in caring for underserved populations in a rich clinical environment. We have strong adult and child residency training programs and a fellowship training program in Psychosomatic Medicine (C/L) which provide opportunities for teaching. Academic appointment, as determined by the criteria of Harvard Medical School, is anticipated.

Qualifications: BE/BC, demonstrated commitment to public sector populations, experience in women's mental health, strong clinical skills, excellent collaborator, problem solver. Bilingual and/or bicultural abilities and training in C/L Psychiatry are desirable. 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 Derri Shtasel, MD, Dept. of Psychiatry, 1493 Cambridge Street, Cambridge, MA 02139. Fax 617-665-2521. Email: DShtasel@challiance.org** (email preferred).

BOSTON & SUBURBS! Part-time & fulltime - NO CALL. Salary, benefits & bonus offered. **Jamaica Plain, Westwood and Pembroke locations**. Child or General Psychiatrists for inpatient/partial programs. Administrative/Clinical duties an option. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

MICHIGAN

GRAND RAPIDS: General & Child Psychiatrists. Inpatient & outpatient for general & specialty programs. Great practice & patient care, collegial staff and community to live in. Top salary, benefits and more. Contact Joy Lankswert @ 866-227-5415; email joy.lankswert@uhsinc.com

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Medical Director Sault Ste. Marie, MI

Horizon Health, in partnership with **War Memorial Hospital in Sault Ste. Marie, MI**, seeks a **Medical Director** for a new 20-bed Adult Inpatient Psychiatric Program. The Upper Peninsula of Michigan is known as one of the most beautiful locations in all of the U.S., abounding in outdoor/recreational activities and possessing some of the most breathtaking scenery in North America. Excellent practice and income opportunity with attractive salary/full benefits/malpractice ins./CME/relocation, and more offered through the hospital. Additional generous Medical Director stipend offered through Horizon Health for Administrative duties. Contact: Mark Blakeney, Horizon Health, 972-420-7473, fax CV: 972-420-8233, or email mark.blakeney@horizonhealth.com. EOE.

Rochester Hills, MI - Very Lucrative Practice Opportunity - If being your own boss and having the freedom to set your own work schedule is what you've wanted, then please call me. This is an opportunity to open an inpatient (adult) and outpatient private practice in the Detroit area. Or if you have a practice already, adding our inpatient component to your income could be extremely lucrative. We will help market your practice in the area. Call is 1 in 4. Please **call Terry B. Good at 1-866-865-7380**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com. Or mail CV to: 1663 Denton Lane, Hayes, VA 23072. EOE

MINNESOTA

CMS
DEDICATED PEOPLE MAKING A DIFFERENCE
Correctional Medical Services

Correctional Medical Services (CMS) is the nation's leader in providing exceptional medical care for correctional facilities.
We provide healthcare to more than 200,000 inmates in over 200 correctional facilities in 25 states.
Facilities located in Minneapolis, MN are in need of Psychiatrist's.
No Call, No Nights and No Weekends!
Very competitive compensation!
Please contact Renee for more information.

Renee Holloway
Recruitment Department
800-325-4809 ext. 9536
314-919-8803-fax
rholloway@cmsstl.com
www.cmsstl.com

Psychiatrists

40 Hour Work Week

The Federal Medical Center, Rochester, MN, is an accredited JCAHO medical and psychiatric referral center for the Federal Bureau of Prisons.

The Psychiatrist works closely with a multi-disciplinary team consisting of health care, mental health care, social work, rehabilitation services, and correctional professionals to provide diagnostic and treatment services to federal inmates. Opportunities exist for teaching medical and allied health professions students, residents, and fellows.

The Federal Bureau of Prisons, Health Services Division, is committed to providing evidence-based medical and psychiatric treatment and has a national impact through the development of comprehensive medical and psychiatric clinical guidelines.

The Federal Bureau of Prisons offers a competitive salary and benefits package. The Federal Bureau of Prisons is an Equal Opportunity Employer.

Contact: Lynn Platte, Medical Recruiter lplatte@bop.gov or call (507) 424-5121

MISSOURI

PSYCHIATRIST

Southwest Missouri Psychiatric Rehabilitation Center, a state run In-patient facility serving both acute and long-term clients, located in the scenic Ozarks of Southwest Missouri is seeking a half-time Psychiatrist. The position will have an active role as lead member of an interdisciplinary treatment setting dedicated to quality service. Minimum qualifications include: M.D. or D.O. with residency completion in psychiatry, board eligible or board certified, and licensed to practice in Missouri. The facility is located in a relaxed rural setting within a short driving distance of major metropolitan and lake resort areas. Salary and schedule negotiable.

Please forward Curriculum Vita to: Human Resources, Southwest Missouri Rehabilitation Center, 1301 Industrial Parkway East, El Dorado Springs, Missouri 64744, Fax to 417-876-1004 or e-mail james.stacy@dmh.mo.gov

The Missouri Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, national origin, disability or age of applicants or employees.

An Hour From St. Louis - Seeking a Psychiatrist for a 10-bed Geropsychiatric Unit in a general hospital an hour from St. Louis. Offering a salary of $200k plus benefits and possible bonus plan (income guarantee for private practice model is also available). Position consists of inpatient & outpatient clinical care and part-time administrative duties such as QA, UR, heading up treatment team, etc. Relocation package is available, however, commuting from St. Louis is also acceptable. Please **call Terry B. Good, Horizon Health, at 1-866-865-7380**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com. Or mail CV to: 1663 Denton Lane, Hayes, VA 23072. EOE

Small Town Living - BIG Opportunity - Horizon Health is seeking a Medical Director for a well-established 12-bed geropsychiatric unit based in a med/surg hospital. Can offer **salary of $210k plus benefits plus an extremely lucrative bonus plan.** A practice guarantee and directorship stipend is also an option. Very low stress work environment; very experienced, quality staff in place that make the psychiatrist's life so much easier; a great place to work! AAA rated public school system; wonderfully diversified economy. 38 minutes from Cape Girardeau; about two hours from St. Louis and Memphis. Please **call Terry B. Good, Horizon Health, at 1-866-865-7380**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com. Or mail CV to: 1663 Denton Lane, Hayes, VA 23072. EOE

Midwest College town!
Great Opportunity! The largest healthcare provider in Missouri is recruiting for an ADULT PSYCHIATRIST! Wonderful support staff, compensation over 200k! J-1 candidates welcome to apply. For more information on this opportunity or others nationwide, contact Lindsay McCartney at: (800) 735-8261 ext 213; FAX your CV to: (703)-995-0647 or Email: lmccartney@medsourceconsultants.com

MONTANA

PSYCHIATRIST-Seeking full-time board certified psychiatrist to fill staff position in VA Montana Healthcare System. Responsibilities include adult outpatient treatment with urgent care/walk-in service and inpatient consultation service in a facility where state-of-the-art medicine is practiced. Fort Harrison Hospital is located in Helena, the State Capital. Competitive salary, benefits and liability included. Additional information can be found at www.vacareers.va.gov. Fax curriculum vitae to 406-447-7978 or call at 406-447-7566 for additional information. EOE.

NEBRASKA

Psychiatrist opening:
Prospective psychiatrist will prescribe, direct, and administer psychotherapeutic treatments and/or medications to treat mental, emotional, or behavioral disorders. Candidate must analyze/evaluate data and test findings to diagnose nature and extent of mental disorders, examine or conduct laboratory or diagnostic tests on patients to provide information on general physical condition and mental disorders. Candidate must counsel inpatients or outpatients during visits and review and evaluate treatment procedures and outcomes of other medical professionals. Ideal candidate will exhibit exemplary skills in active listening, critical thinking, and complex problem solving with problem sensitivity. Candidate would effectively advise and inform guardians, relatives, and significant other of patients' conditions and treatment.

Minimum requirements: Must have MD or equivalent and Nebraska Medical License; maintain Board eligibility or Board certification in Psychiatry; have 3 years of training in Psychiatry and 1 year of internship. Minimum 40 hours per week with on-call and weekend duty.

Contact: Marcia Baumann, Great Plains Regional Medical Center, North Platte, NE at 308-696-7409 or baumanm@mail.gprmc.com.

NEW HAMPSHIRE

Staff Psychiatrist
Community Council of Nashua, NH

Our dynamic comprehensive community mental health center located in scenic New England, is seeking a full time BE/BC psychiatrist to join our medical staff. Responsibilities include providing psychiatric evaluations and on going psychiatric service in an adult, outpatient clinic setting. The psychiatrist heads a treatment team and provides direct supervision and management of clinical staff. Research opportunities available. Paid call is shared with 5 other physicians. Attractive compensation and benefits package, 45 minutes from Boston, in tax free New Hampshire. Nashua, NH is easily accessible to major airports, mountains and lake regions.
Send CV to:

Hisham Hafez, MD
Executive Director/Chief Medical Officer
Community Council of Nashua, NH
7 Prospect St., Nashua, NH 03060.
hr@cofnashua.org

ADULT PSYCHIATRIST

Monadnock Family Services is a community mental health center offering assessment, counseling, support, education and referral services to children and adults of all ages. Position available with an innovative behavioral health agency with a 100-year history. Monadnock Family Services is a leader in area health and social services, alliances, and partnerships. Creative, innovative and supportive climate in the beautiful Monadnock region of N.H. - 90 miles from Boston; near many excellent recreational and cultural activities. MFS is seeking a 5-day per week general psychiatrist to work primarily with adult clients (including the geriatric population) with persistent mental illness for our community mental health center. The psychiatrist in this position works as a clinical leader in an interdisciplinary team consisting of various mental health professionals who provide services based in the recovery and evidence-based practice models of treatment. Candidate must be Board Certified or eligible in psychiatry, have current credentials to practice medicine in the US, and have a desire to work with individuals with severe and persistent mental illness. Competitive salary and fringe benefits with generous vacation leave, 11 paid holidays and sabbatical program. Infrequent on-call coverage required. *Our staff enjoys a generous benefit package, including health, dental, flexible-spending plan and company-provided LTD, AD&D and Life insurance and 3 weeks of vacation during the first year of employment.*
Please send resumes in confidence to: MONADNOCK FAMILY SERVICES ATTN: Human Resources, 17 93rd Street, Dept. PN, Keene, NH 03431 Or to Humanresources@mfs.org

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PSYCHIATRIST
Portsmouth, NH

Beautiful Seacoast area with four seasons, 55 minutes from Boston. Expanding private, non-profit community mental health center seeks two psychiatrists, one child and adolescent and one adult, to join a staff of seven psychiatrists, for outpatient care. Vibrant collegial atmosphere with competitive salary and excellent benefits package.

Interested candidates should send cover letter and C.V. to W.M. Hanna. M.D., Medical Director.

Seacoast Mental Health Center, Inc.
1145 Sagamore Avenue
Portsmouth, NH 03801
Fax: 603-433-5093

NEW JERSEY

Child/Adol. or Adult Psychiatrists

Child/Adol. or Adult Psychiatrists - needed for multi-disciplinary group in affluent community in North/Central N.J. NO Managed Care! Call Dr. S. Reiter at 908-598-2400 x1 and/or fax CV to 908-598-2408.

Psychiatrist - Established, for profit outpatient mental health practice with offices in South Jersey and Philadelphia. Immediate opening for experienced Adult Psychiatrist and Child and Adolescent Psychiatrist. Excellent referral base and reputation. Private practice model within comprehensive multi-disciplinary group of highly qualified clinicians. Fax CV to 856-985-8148 or call 856-983-3866 ext. 3018.

SOUTH JERSEY near Cherry Hill. General or Addiction Psychiatrist for adult general psychiatric & dual diagnoses inpatient treatment programs. Salary, benefits, and bonus plan offered. Nominal call. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

NEW MEXICO

Mental Health Resources, Inc. of Clovis, New Mexico has an immediate need for a full-time or part-time psychiatrist to add to its medical staff. Vacancy is for a psychiatric generalist who would enjoy a small town environment. Area is approved for J-1 or H-1 placement. Contact Dr. Cecilia Carpio, Medical Director, Mental Health Resources, Inc., 1100 West 21st St., Clovis, NM 88101. mhrnewmex@yucca.net

NEW YORK CITY & AREA

Premier HealthCare

BC/BE Psychiatrists

Child/Adolescent & Adult
Brooklyn, Bronx & Manhattan
Full Time/Part Time/Fee for Service

YAI/Premier Healthcare is a nationally recognized, well-established NYC diagnostic & treatment center for people with disabilities and their families. We are currently seeking NY Licensed psychiatrists.
Brooklyn Heights or Sheepshead Bay Brooklyn, Throgs Neck Bronx & Midtown Manhattan.
This is an opportunity to work with a professional team of doctors and nurses in a multi-cultural, team environment. Send CV to:
Karen Meyers, Clinical Recruiter, Premier HealthCare, 460 West 34 Street, N.Y., N.Y. 10001 Fax 212-563-4836 Email: kmeyers@yai.org

Deadlines:
Dec 21 issue - Dec 7
Jan 4 issue - Dec 19

PSYCHIATRISTS
Lutheran Medical Center and Lutheran Family Health Centers in Southwest Brooklyn, offering a continuum of community-oriented behavioral health services under the auspices of the Department of Psychiatry, has openings for the following:

F/T MEDICAL DIRECTOR/OUTPATIENT BEHAVIORAL HEALTH-provide overall clinical leadership for ambulatory behavioral health services in an FQHC network in Southwest Brooklyn. Includes leadership and supervision of psychiatrists, nurse practitioners, and non-psychiatric behavioral health clinicians. Evaluate and treat patients, collaborate with Administrative Director on programs and operations, lead incident reviews, participate in audits, design and implement quality improvement activities, participate in ongoing development and implementation of an EMR. Report to Chairman, Dept. of Psychiatry, Lutheran Medical Center. Requires Board Certification in Psychiatry and 5+ years post-residency clinical/administrative experience (Unit Chief, Service Director, etc.) Additional Fellowship training/ certification and language capability preferred but not required. Clinical academic appointment at affiliated SUNY Downstate is available and encouraged. Position is ideal for a candidate with career goal of advancing as physician administrator/physician executive.

F/T INPATIENT PSYCHIATRIST-participate in multidisciplinary teamwork on a 35-bed IP Psychiatric Unit with 2 psychiatric colleagues and a Chief. Provide once-weekly psychiatric

consultation on adjacent Detox Unit. Includes medical student teaching. Bilingual Spanish, Mandarin Chinese or Arabic a plus.

F/T OUTPATIENT ADDICTION PSYCHIATRIST-Fellowship -trained, addiction-Boarded or ASAM-certified psychiatrist to join OP adult substance abuse/MICA team for direct patient care, including buprenorphine treatment, in FQHC network site. Qualifying for loan repayment may be possible due to HPSA designation.

MOONLIGHTING PSYCHIATRISTS-opportunities in Inpatient/ ED/CL/Detox Services on select weekly shifts.

Please fax 718-630-8594, email: bgoff@lmcmc.com or send resume/CV to: Bradford M. Goff, M.D., Chairman, Dept. of Psychiatry, Lutheran Medical Center, Suite 2-45, 150 55th Street, Brooklyn, NY 11220. EOE/AA M/F/D/V

LUTHERAN MEDICAL CENTER
www.LutheranMedicalCenter.com

Psychiatrist - Child/Adolescent

The George Jervis Clinic at the Institute for Basic Research in Developmental Disabilities seeks a Board-Certified or Eligible Child/Adult Psychiatrist, Full or Part-Time to serve as a member of a multidisciplinary team. We provide diagnostic and evaluative services to persons with disabilities and their families. Must be licensed or eligible in the State of New York. Experience with MR/DD and Autistic population preferred. Teaching or research background a plus. Research opportunities with basic researchers or collaboration with clinicians are available. Affiliation with State University system is possible. Regular hours with no call responsibilities. Excellent benefits package. Salary based on qualifications and/or experience. We offer a unique opportunity for the dedicated professional who wishes to provide needed services while contributing to the body of research in Developmental Disabilities. Fax application to (718) 494-7917 or mail to Human Resources Office; please include posting **# S-07-20**, Institute for Basic Research in Developmental Disabilities, 1050 Forest Hill Road, Staten Island, NY 10314. IBR/DD is an EO/AA Employer.

NEW YORK STATE GERIATRIC PSYCHIATRIST

The State University at Buffalo School of Medicine and Biomedical Sciences (SMBS) Department of Psychiatry seeks ABPN Board Certified **GERIATRIC PSYCHIATRIST.** Development of Geriatric Psychiatry dedicated services encouraged, esp. OPD. Coverage of six beds on an eighteen bed geriatric psychiatry In-patient unit. Educational opportunities at all levels (medical students, residents PGY1-4, interdisciplinary) available. Active participation in newly ACGME accredited (2006) PGY5 in Geriatric Psychiatry. Research encouraged and supported with statistical help, project development, and grant submission, within department as needed. Research and grant experience preferred. Interdisciplinary collaborations encouraged, especially with Geriatrics, other clinical departments, and other departments within the University. Opportunities to participate in clinical trials available. Participation in the University supported Institute for Research and Education of Women and Gender (IREWG) available. Administrative responsibilities in the Division will become available for suitable candidate. Salary and benefits are highly competitive, with protected time for research for qualified faculty. Faculty appointment at level commensurate with experience. This position opening is an exceptional opportunity to develop your academic career or bring what you already have established to this vibrant Department, Medical School, and University with its abundant opportunities. Here you enjoy beautiful seasonal intensities, live in a culturally rich environment with many sports interests, affordable real estate, and excellent schools. To apply: Send letter of interest, CV (including states licensed), three professional reference contacts to:

Steven Dubovsky, MD
Chair and Professor of Psychiatry
dubovsky@buffalo.edu
with copy to
Marion Zucker Goldstein, MD
Professor of Psychiatry
Division and Program Director Geriatric Psychiatry
mzg@buffalo.edu

SUNY at Buffalo is an affirmative action equal opportunity employer.

NEW YORK STATE

EXCELLENT ADULT PSYCHIATRY OPPORTUNITY - Samaritan Medical Center, a not-for-profit regional referral center in northern New York, is seeking a BC/BE Psychiatrist for hospital based employment to join our excellent dedicated staff, recently awarded the *National Best Practice Award for Customer Service*. Physician will provide adult psychiatric care in our 32 bed inpatient mental health unit. Physician will also serve as consultation liaison and participate in rotational emergency call. **Top salary, signing bonus, excellent benefits, malpractice coverage, relocation assistance, immigration assistance, etc**. Enjoy the natural beauty of northern New York 1,000 Islands Region, with the added benefit of living in a safe community with a low cost of living. **For more information contact Anne Marie Walldroff at 315-785-4632, or respond online to awalldroff@shsny.com. Visit our website: www.samaritanhealth.com**

GREATER BINGHAMTON HEALTH CENTER

ADULT PSYCHIATRISTS and CHILD/ADOLESCENT PSYCHIATRISTS

GBHC (JCAHO-Accredited New York State Office of Mental Health facility) is seeking full time; board certified/board eligible **ADULT PSYCHIATRISTS** for its adult inpatient facility and **CHILD/ADOLESCENT PSYCHIATRISTS** for its Child/Adolescent Behavioral Health Center. Abundant on-site CME. Salaried, permanent positions with excellent New York State benefits. No evening or weekend call required. Compensated optional call available. Enjoy the reasonable cost of living Central New York offers with easy access to NYC and other major cities.

Submit CV to:
Human Resources
Greater Binghamton Health Center
425 Robinson St., Binghamton, NY 13904
Fax: (607) 773-4117. EOE/AAE

Forensic Psychiatry / Child Psychiatry / Adult Psychiatry: St. Lawrence Psychiatric Center, a fully accredited, EO-AAE, seeks BC/BE Psychiatrists licensed to practice medicine in NYS (or eligible to obtain NYS license) to work either full or part time at our 80-bed, Civil Management, Sexual Offender Treatment Program (Additional training in forensic psychiatry is helpful, but not required;) Child Psychiatrists to work in a Children and Adolescent Inpatient or Outpatient Unit; and Adult Psychiatrists to work in an Adult Inpatient or Outpatient Clinic. We are designated by Federal Government as M.H.P.S.A. In addition to salary ($149,722 to $159,965) and guaranteed additional compensation by voluntary participation in an on-call program, we offer an excellent benefit package including: malpractice insurance, health insurance, paid vacation, holiday and sick time, an excellent retirement plan and educational and professional leaves.

Situated on the scenic St. Lawrence Seaway in northern New York, St. Lawrence Psychiatric Center is located on Ogdensburg, NY, an idyllic rural community offering many cultural, educational and economic opportunities. Historic and international metropolitan cultures are a reasonable driving distance away in Ottawa and Montreal, Canada and Syracuse, NY. Ogdensburg's location on the St. Lawrence River and its close proximity to the Adirondack Mountains and Canada offers easy access to a wide variety of unspoiled natural areas and rich cultures and provides abundant recreational opportunities throughout the year.

Submit letter of interest to: Hari Sanghi, MD, Clinical Director, St. Lawrence Psychiatric Center, One Chimney Point Drive, Ogdensburg, NY 13669 or at slmdhls@ohm.state.ny.us. If you have questions, please call (315) 541-2117.

Staff Psychiatrist

Ulster County Mental Health, an outpatient mental health clinic with a wide range of services, has a position for a full-time psychiatrist in the Ellenville satellite clinic. Child experience desirable, but not necessary. We are located in the beautiful Hudson Valley, two hours north of NYC. Competitive salary, good benefits, on-site psychopharmacology supervision and collegial atmosphere. No on-call or weekends. Full-time 35 hours. Send CV to Julia Adamczak, MD, Medical Director, Fax #845-340-4094. Telephone #845-340-4173.

NORTH CAROLINA

The Section of Child and Adolescent Psychiatry at Wake Forest University Health Sciences Department of Psychiatry is seeking a Program Director for the Child and Adolescent Psychiatry Residency Training Program. The training program is fully accredited with RRC approval for 3 residents per year. Applicants must possess an MD or equivalent degree, be board certified in Child and Adolescent Psychiatry, and have demonstrated excellent qualifications in education and clinical care. The successful candidate will have 50% protected time for the training program with additional effort spent in the education of General Psychiatry residents and medical students as well as patient care. Wake Forest University Baptist Medical Center has a thriving Pediatric Behavioral Health inpatient unit which is part of the Brenner Children's Hospital. Clinical opportunities are also available in the outpatient arena and via the consult service. Research opportunities are available and participation in scholarly activity is expected.

Wake Forest University Health Sciences is an equal opportunity employer. Women and minorities are encouraged to apply.

Please submit a curriculum vitae and letter of interest to:

Guy K. Palmes, M.D.
Assistant Professor and Section Head
Child and Adolescent Psychiatry Section
Department of Psychiatry
Wake Forest University Health Sciences
Medical Center Blvd
Winston-Salem, NC 27157-1087
(336)716-5089

Or electronically at gpalmes@wfubmc.edu

Wilmington, North Carolina Psychiatry Opportunity

Wilmington, NC

New Hanover Regional Medical Center seeks to hire Inpatient-based Psychiatrists to provide services within the medical center and the Behavioral Health Hospital, The Oaks. A 62-bed psychiatric hospital on the New Hanover Regional Medical Center campus, The Oaks provides inpatient and outpatient psychiatric programs for adults. The Oaks staff is specially trained to evaluate and treat patients for depressions, adjustment disorders, bipolar disorder, schizophrenia, psychotic and personality disorders. Inpatient units include: Dual-Diagnosis Unit, Behavioral Medicine Unit and Progressive Treatment Unit. Team consists of four physicians and a mid-level provider. Call is 1 in 4.

Ideal candidates must have a strong work ethic, good interpersonal and communication skills, a commitment to excellent patient care and a team-oriented attitude.

Being a Southern coastal town, Wilmington offers a variety of activities from a historic riverfront downtown, Thalian Hall performing arts center, museums, beaches and water activities, fishing, nightlife and great restaurants. Wilmington offers many family oriented communities and activities. Additionally, area schools are identified as some of the top in the state while the local university provides further educational opportunities. For more information about the Wilmington area, you may go to http://www.wilmingtonchamber.org/

Position is a hospital employment model with excellent salary and benefits. Interested candidates should forward their CV to Kathy Gresham, Director, Physician Relations, New Hanover Regional Medical Center, 910-452-8772 or email Kathy.Gresham@nhhn.org

Eastern NC - Convenient to Outer Banks, NC and Norfolk/VA Beach - Horizon Health has a very attractive salaried position with benefits in a general hospital located in an area that is becoming one of THE places to retire in NC. This is an inpatient and outpatient position. You would work with a great group of people that make work a pleasure every day. What could be better: low stress small town living with a wonderful climate and easy drive to the coast plus a very rewarding professional opportunity. Join two other psychiatrists making call 1 in 3. Please **call Terry B. Good at 1-866-865-7380**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com. Or mail CV to: 1663 Denton Lane, Hayes, VA 23072.

CLOSE TO RALEIGH AND GREENVILLE - VERY LUCRATIVE COMPENSATION PACKAGE - Horizon Health seeks a Psychiatrist for a Medical Director position on an adult unit and CD unit in a very impressive general hospital in Rocky Mount. Offering a salary with benefits plus bonus plan or practice guarantee and stipend. What a great location! Enjoy the wonderful climate and quality of life this lovely area offers-only 45 minutes from Raleigh and Greenville & an easy drive to the mountains or the beach. Please **call Terry B. Good at 1-866-865-7380**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com. Or mail CV to: 1663 Denton Lane, Hayes, VA 23072.

OHIO

Full-time opportunity for a child/adolescent psychiatrist or general psychiatrist willing to treat adolescents. MHS is a comprehensive community mental health center offering inpatient, outpatient, partial hospital, and community support programs. Located in a safe, family-friendly, community located less than an hour from Columbus and Dayton and offering an abundance of natural, cultural, educational and entertainment venues. Competitive salary and benefit package including 20 days vacation, plus paid sick and personal time, health, dental and life insurance, FSA, company-funded retirement plan, CME, and professional dues. Must be board-certified or board-eligible. Visit www.mhscc.org for more information and to download a brochure. Please send letter of interest and vita to J. Marenberg, HR Director, Mental Health Services for Clark Co. 1345 N. Fountain Blvd. Springfield, OH 45504, Jo.Marenberg@mhscc.org or fax to 937 342-4254. Equal Opportunity Employer.

CMS
DEDICATED PEOPLE MAKING A DIFFERENCE
Correctional Medical Services

Correctional Medical Services (CMS) is the nation's leader in providing exceptional medical care for correctional facilities.
We provide healthcare to more than 200,000 inmates in over 200 correctional facilities in 25 states.
You can improve your lifestyle with regular and reasonable schedule.
Facility in Leavittsburg, OH-1 hour Southeast of Cleveland-would like to add a Psychiatrist.
Residential Treatment Unit is staffed with very knowledgeable RN's and Social Workers.
90 bed Inpatient unit.
Very competitive compensation.
Please contact Renee for more information.

Renee Holloway
Recruitment Department
800-325-4809 ext. 9536
314-919-8803-fax
rholloway@cmsstl.com
www.cmsstl.com

CINCINNATI SUBURB - GEROPSYCH
Staff Psychiatrist position available on geropsychiatric services in a very impressive not-for-profit general hospital in a suburb of Cincinnati only 8 miles from the University of Cincinnati Medical School. Work consists of inpatient and outpatient work with some medical floor consults; nursing home work is available if desired as well as work on adult unit. Offering excellent salary with benefits. Please **call Terry B. Good, Horizon Health, at 1-866-865-7380**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com. Or mail CV to: 1663 Denton Lane, Hayes, VA 23072.

OREGON

Private Practice opportunity in Bend, Oregon. This is both an outpatient and inpatient practice. The inpatient units are primarily adult-20 beds total, with consult/liaison services. We are jointly recruiting with St. Charles Medical Center, the largest medical center east of the Cascades. The hospital is offering a practice guarantee, interview and moving expenses. Bend is nestled in the beautiful Cascades three hours driving time from Portland, with great restaurants, golf, skiing, kayaking, mountain biking and many other recreational activities.
Email CV to Magnus Lakovics, MD, Medical Director, Behavioral Health Services, St. Charles Medical Center at mlakovics@msn.com or call 541-390-4418.

PRIVATE PRACTICE: Unique opportunity for solo practitioner to share office space, overhead/operating expenses, and a collegial atmosphere with 11 well-established, well-esteemed, psychodynamically oriented solo private practice psychiatrists in a remodeled historic home in NW Portland. Please contact Richard Alden MD (503-228-5909, ext.110) for further information.

PENNSYLVANIA

PART TIME, to start, PSYCHIATRIST for creative, busy, insurance-based, MD-owned, mh practice in Delaware County PA. Medication mgt, some therapy poss., +teamwork w/txists. Child & adolescent experience & interest preferred. Please see us at www.PsychChoices.com & send resume, if interested, to noahdfreedman@gmail.com.

CRISIS MEDICAL DIRECTOR

Mercy Fitzgerald Hospital in Southeastern Delaware County is recruiting a full time Psychiatrist for weekday work as Medical Director of our crisis center. Full time is with group practice involvement and includes benefits, malpractice and high income potential. Part time positions in crisis also considered. Please contact Jeffrey J. Dekret, M.D., Director of Psychiatry by fax 610-237-4695, email: jdekret@mercyhealth.org or call 610-237-4123.

Pennsylvania: MHM Correctional Services, Inc. the leading national specialist in providing mental health programs and services to correctional systems invites you to join us in one of these outstanding opportunities with the Pennsylvania Department of Corrections. Full-time positions currently exist at SCI Camp Hill (Harrisburg, PA) and SCI Huntingdon (Central PA) as well as a part-time (12 hrs/wk) positions at SCI Pine Grove (Indiana, PA). We are seeking Psychiatrists who are ready to make a difference to an underserved population while being part of an elite organization that offers outstanding benefits and generous compensation. Gain personal and professional satisfaction, while utilizing your skills in a safe and supportive work environment. Guide the delivery of mental health services to this diverse population of incarcerated individuals. Contact Holley Schwieterman at: (866) 204-3920 or email: hschwieterman@mhm-services.com to learn more. www.mhm-services.com

EEO/AA

Salaried Position in Great Lakes Region - General Psychiatrist needed for equally mixed in-patient/out-patient psychiatric unit and private office setting with large, 277-bed, community hospital. Employed position with competitive salary and compensation package including full benefits, paid malpractice, sign-on bonus, relocation expenses and more. Call is extremely reasonable. Join two enthusiastic psychiatrists in dynamic practice setting with appreciative patients and staff. Enjoy comforts of city living in a welcoming suburban community. Contact Shelly Berasi: 814-333-5018, fax CV's in confidence to 814-373-2269 or email mberasi@mmchs.org.

Metropolitan Pittsburgh established multidisciplinary psychiatric group seeks full time general psychiatrist to lead on of our inpatient programs. 1st year salary guarantee. Excellent benefits. Robust income potential. J-1 available.

Contact: Deborah Solari
Practice Administrator
724-282-1627
www.pbsmentalhealth.com

Philadelphia Burbs! Great opportunity for a Adult Psychiatrist! Local Behavioral Health Center is seeking a full-time Adult Psychiatrist (Can be C&A if interested)-This position is a mix of inpatient and outpatient on a licensed for 18 bed unit and some consults. If C& A psychiatrist the position can be working with mostly C& A patients. If general psychiatrist, the position will be all adult patients. Salary starts at $170K, depending on boards and experience, and full comprehensive benefits. Please contact Loree Frazitta @ 800-735-8261 Ext. 216, fax your CV to 703-995-0647, or email your CV to lfrazitta@medsourceconsultants.com.

RHODE ISLAND

PSYCHIATRIST

The Providence Center, a JCAHO facility, is recruiting a psychiatrist to join a medical staff of 10 other full-time psychiatrists in a well respected community mental health center. The Center provides a wide spectrum of outpatient and residential services. Job responsibilities are varied. Board certification or eligibility is required. Experience working in a multidisciplinary setting is preferred. The position offers comprehensive benefits and competitive salary. The Center is a J1 site.

Contact:
Michael A. Silver, M.D.
The Providence Center
530 North Main Street
Providence, RI 02904
Phone: 401-276-6359
Fax: 401-276-4034
Email: msilver@provctr.org

LIFESPAN PSYCHIATRY

Rhode Island Hospital
The Miriam Hospital

Affiliated hospitals of the Warren Alpert School of Medicine at Brown University
Department of Psychiatry & Human Behavior

Because of the growth and success of our programs, we are recruiting a number of full-time clinical positions that are part of an academic medical center program with significant teaching and research activities. Because these positions have opportunities for teaching Brown University trainees, they are eligible to be considered for Clinical Faculty appointments. There are possibilities for research participation for applicants with the appropriate background and interests.

Outpatient: 2-3 additional psychiatrists needed to participate in multidisciplinary programs, with general psychiatry populations. Special interests which would be relevant include: general outpatient practice, mood disorders, behavioral medicine, HIV-immunology, and neuropsychiatry.

Adult Partial Hospital: is seeking 1-2 additional psychiatrists to support expansion. This acute care program is an innovative, evidence-based, and psychodynamically focused practice, specializing in interpersonal and existential models of treatment. Expertise in geriatrics is particularly desired.

Consultation-Liaison: part time positions are available, including interface with specialized emergency department programs.

Emergency Psychiatry: several positions are available, involving supervision and teaching of Brown University residents: positions include times on weekday evenings from 5 PM to 10 PM; some positions include weekend times in lieu of weekdays.

Applicants must be Board Certified in Psychiatry or Board eligible (within three years of training completion). Salary and benefits commensurate with level of training and experience. 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 02906 and/or email to rjgoldberg@lifespan.org.

SOUTH CAROLINA

ONE HOUR FROM MYRTLE BEACH & COLUMBIA - Medical Director, Inpatient and Outpatient Geriatric Psychiatry - Due to growth, Horizon Health has an opening on a new 12-bed geriatric psychiatry program in a general hospital in Florence-a lovely area. The Behavioral Health program is part of a 372-bed hospital system that serves a nine-county area. The cost of living is relatively low in Florence and the residents are known for their southern hospitality. Offering directorship stipend and income guarantee, however, salary with benefits may be an option. Board Certification in Adult Psychiatry is required. Contact Terry B. Good, 866-865-7380, Fax: 804-684-5663; E-mail: terry.good@horizonhealth.com. EOE

TENNESSEE

VANDERBILT UNIVERSITY FACULTY POSITION

Vanderbilt University Department of Psychiatry (Nashville, TN) is recruiting BE/BC full-time faculty psychiatrists (Adult or Child) with interest in inpatient psychiatry in an academic setting. Teaching and participation in clinical research will complement the clinical work. Appointment will be at the Assistant Professor level or above. Salary is negotiable dependent upon qualifications and experience.

For further information, please contact: Sherron Buchanan, Assistant to Chair, 1601 23rd Avenue South, Suite 3060, Nashville, TN 37212 - Phone: 615-322-2665; Fax: 615-343-8400

TEXAS

Child & Adult Psychiatrists - Assistant Professors
Adult Psychiatrist - Associate Professor

The **Department of Psychiatry at The University of Texas M.D. Anderson Cancer Center** is recruiting board-certified/eligible child & adult psychiatrists at the Assistant Professor level and an adult psychiatrist at the Associate Professor level to join its full-time faculty. We seek individuals with experience or training in clinical consultation-liaison psychiatry/psycho-oncology and an interest in research. Our faculty provide clinical expertise in patient care and management for patients suffering with psychiatric and behavioral disturbances related to cancer treatment. The successful candidates would also participate in the training of psychiatry fellows, residents and medical students in the specialty of psycho-oncology. In addition, they would be responsible for the development and conduct of research related to behavioral, psychiatric and psychosocial problems in cancer patients and their families.

Interested applicants should submit a curriculum vitae and a letter describing their clinical and academic interests to: **Alan Valentine, M.D., Department of Psychiatry, P.O. Box 301402, Unit 453, Houston, Texas 77230, Phone: 713-792-7546 Fax: 713-792-8242, E-mail: avalenti@mdanderson.org**

M. D. Anderson Cancer Center is an equal opportunity employer and does not discriminate on the basis of race, color, national origin, gender, sexual orientation, age, religion, disability or veteran status except where such distinction is required by law. All positions at The University of Texas M. D. Anderson Cancer Center are security sensitive and subject to examination of criminal history record information. Smoke-free and drug-free environment.

The Holiner Psychiatric Group located in Dallas, Texas seeks a psychiatrist to join its well-established six physician psychiatric practice. This position offers an excellent opportunity to build a full practice in short period of time.

- Competitive salary with incentive plan. Offer includes medical and dental benefits, pension plan, malpractice insurance, vacation and sick time.
- Progressive growing outpatient/inpatient growing practice needing additional physicians to serve a patient population including children, adolescents, adults and geriatrics.
- Collaborative team of six psychiatrists, two psychologists, seven advanced nurse practitioners along with a well-trained support staff.

For further information please contact suzan.holiner@medicalcitydallas.com or call 972-566-4329.

DALLAS area (Sherman) and SAN ANGELO: Private practice opportunities - General, Geriatric or Child Psychiatrists. Service Directorship & caseload stipend or income guarantee depending on location. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

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Presbyterian Hospital of Dallas
Texas Health Resources

Medical Director needed in Dallas, Texas!

We are looking for a medical director to staff our adult psych inpatient unit that has recently expanded to 41 beds. Unit specialty areas include detox, eating disorders, geropsych, and ECT.

Please contact Norma Ondarza,
Texas Health Resources (800) 945-0430,
NormaOndarza@TexasHealth.org. Please visit us at www.texashealth.org

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AUSTIN: Busy private practice group seeking adult and/or child psychiatrist. Texas license and BE/BC required. Primarily out-patient. In patient optional. Ample referrals. Office well staffed and equipped. Austin is a great place to live and raise a family. Contact Neuropsychiatric Associates of Austin @ (512) 454-5716 or e-mail np_associates@prodigy.net.

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The Center for Health Care Services, a 2006 APA Gold Award winner, is actively seeking full-time/part-time/contract psychiatrists for our Adult & Child Programs. The Center Psychiatrists are at the leading edge of the delivery of mental health service, providing assessment and treatment of clients, and leadership of a team of skilled and dedicated mental health professionals. Must be board eligible or board certified.

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If you are interested in learning more about service at The Center, please submit your C.V. in confidence to:

The Center for Health Care Services
Attn: HR Director
3031 IH 10 West
San Antonio, Texas 78201
Fax: 210-731-1310
staffing@chcs.hhscn.org

EOE

UTAH

PROVO/OREM: Child Psychiatrist - Adolescent Residential Treatment. Duties include admissions, treatment planning & follow-up. Manageable caseload - patients seen on varied schedules per treatment needs. Compensation includes salary & benefits. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

VERMONT

The Counseling Service of Addison County (CSAC) is currently seeking a Psychiatrist to join an innovative interdisciplinary practice of a highly regarded non-profit community mental health center located in a uniquely desirable small, New England college community. Child/adolescent expertise desired, but not required. Qualifications: BC/BE psychiatrist. CSAC Offers a collaborative environment, rewarding work, a culture of caring, top ranked services, committed staff, excellent benefits, and a lovely location in the Champlain Valley. The Middlebury and Burlington areas offer an outstanding quality of life that boasts magnificent restaurants, world-class shopping, cultural amenities, vibrant downtowns and a natural playground for outdoor activities like golf, tennis, sailing, hiking, biking and, of course, great skiing.
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Please submit cover letter and resume to Cheryl Huntley via email at chuntley@csac-vt.org, fax at (802) 388-8183, or mail to 89 Main Street, Middlebury, VT 05753. For more information you may call her at (802) 388-0302 ext. 493. Visit our website: www.csac-vt.org.

Faculty Position - Division of Public Psychiatry Medical Director for the Vermont State Hospital

The University of Vermont College of Medicine and Fletcher Allen Health Care are seeking a full-time faculty member at the Assistant or Associate Professor level to join a dedicated and enthusiastic team of professionals at the Vermont State Hospital. The Vermont State Hospital is a 52-bed hospital serving both civil and forensic patients, as well as providing consultation to the Vermont Department of Corrections.

The selected candidate for this exciting position will be responsible for providing clinical leadership and medical administration to Vermont State Hospital. He/she will supervise staff psychiatrists, will provide medical administrative direction for the hospital, and will provide clinical care. In addition, the selected candidate will supervise house officers & medical students, and will participate in academic programs of the Department of Psychiatry and the College of Medicine. An ability to work collaboratively with team members as well as with community mental health professionals is essential. An interest in clinical research is encouraged.

Applicants must have a medical degree and be board certified in psychiatry. They must have experience as a medical administrator; experience in inpatient and/or community settings is preferred. Qualifications in Forensic Psychiatry, Addiction Psychiatry or Geriatric Psychiatry are a plus.

Waterbury, Vermont is located in the heart of the fabulous Green Mountains, twenty-eight miles from Burlington in one of the most beautiful areas in New England. It is a wonderful location for families, with excellent public and private schools and year-round recreational opportunities. Burlington is home to the University of Vermont and three independent colleges that provide an academically stimulating and culturally rich environment. Montreal and Boston are within easy driving distances.

Please apply online at www.uvmjobs.com or send a letter of interest, curriculum vitae, and the names, addresses and telephone numbers of three references to:

Thomas A. Simpatico, M.D.
Chair, Search Committee
Vermont State Hospital
103 South Main Street
Waterbury, VT 05671-2501
Email: Thomas.Simpatico@uvm.edu
Voice: (802) 241-3023
Fax: (802) 241-3001

The University of Vermont is an Equal Opportunity and Affirmative Action Employer. Women and people from diverse racial, ethnic, and cultural backgrounds are encouraged to apply. Applications will be accepted until the position is filled.

VIRGINIA

VIRGINIA COMMONWEALTH UNIVERSITY: Dept. of Psychiatry recruiting BE/BC **faculty psychiatrist at Assistant or Associate Professor level,** for mixed inpatient-outpatient position. Inpatient responsibilities include daily teaching rounds on nine beds acute inpatient unit, and outpatient work includes supervision, faculty practice, and visiting community geriatric locations. Fellowship in geriatrics preferred. Pursuit of scholarly work encouraged and supported. VCU is a large urban university with robust health science campus and 750 beds university hospital. Department of Psychiatry employs over 85 full time faculty and is nationally ranked in federally funded research. Richmond, the State Capital, has moderate climate and a rich mix of historical and contemporary facilities. Excellent suburban housing, public/private schools. Internet provides comparative cost of living. Send CV to Marie Baker-Roach, Human Resources, Department of Psychiatry, VCU/MCV, Box 980710, Richmond, VA 23298. VCU is an EEO/AA employer. Women, minorities, and persons with disabilities encouraged to apply.

Child Psychiatrist

Virginia Commonwealth University: Medical College of Virginia Hospitals, Division of Child & Adolescent Psychiatry in the Department of Psychiatry, recruiting Virginia license-eligible BE/BC child psychiatrist faculty as Inpatient/Outpatient attending. Position located in professional shortage area; J-1 candidates welcome to apply. Will be responsible for administration and clinical care as well as teaching and supervision of medical students, residents and child fellows. In addition, consultation work with community agencies will be available. Interest in teaching and academic work, as well as ability to work on interdisciplinary team, required. Department has nine fulltime child psychiatrists and child research institute, over 85 fulltime faculty and well-funded research in genetics, addictions, child and women's mental health and psychopharmacology. VCU is a large urban university with robust health science campus and 750-bed university hospital. Richmond, the State Capital, has moderate climate and rich mix of history with modern facilities, excellent suburban housing, public/private schools. See comparative cost of living via Internet at www.coli.org/. Send CV to Bela Sood, MD, c/o Marie Baker-Roach, VCU, Box 980710, Richmond VA 23298. Virginia Commonwealth University is an Equal Opportunity/Affirmative Action employer. Women, minorities, and persons with disabilities are encouraged to apply.

CARILION CLINIC
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Psychiatrist - Multiple Opportunities Available Carilion Clinic - Virginia

Carilion Clinic in Roanoke, VA has an opening for a full-time BE/BC adult Psychiatrist at Carilion Roanoke Memorial Hospital, an 843-bed academic/tertiary referral center in with 32 acute adult psychiatric beds. Responsibilities include outpatient clinical services for the Department of Psychiatry and Behavioral Medicine, along with teaching medical students and supervising residents in psychiatry. In collaboration with Virginia Tech, Carilion Clinic is establishing its own allopathic medical school opening Fall 2010 with a problem-based learning curriculum. Call 1:10.

Carilion New River Valley Medical Center in Christiansburg, VA has an opening for a full-time BE/BC adult Psychiatrist at Saint Albans Behavioral Health, located a new, 36-bed wing of the medical center. The inpatient psychiatry unit includes an ECT suite, intensive treatment area, geriatric observation, and adjacent outpatient offices for continuity of care. Saint Albans is a training site for medical students at Via College of Osteopathic Medicine on the campus of Virginia Tech in nearby Blacksburg. Call 1:7.

Submit CV and cover letter to Rhonda Creger, Sr Consultant in Professional Staffing, Carilion Clinic, Roanoke, VA, rhondac@carilion.com, 800-856-5206. AA/EEO

Virginia Weekend Positions

Carilion Clinic has weekend positions available in Roanoke and Christiansburg locations. See new patients, do consults and round on 75% of patients over course of two 16-hour weekend shifts (Saturday/Sunday). One weekend off per quarter. Work an additional 2 hours per week with Chair of Psychiatry on projects and qualify for full-time benefits. Submit CV and cover letter to Rhonda Creger, Sr Consultant in Professional Staffing, Carilion Clinic, Roanoke, VA rhondac@carilion.com, 800-856-5206. AA/EEO

Central State Hospital is seeking a psychiatrist with expertise in Public and/or Forensic Psychiatry. Applicants must be licensed or eligible for licensing by the Virginia Board of Medicine (Board certification is preferred.) CSH offers an outstanding benefits package, competitive salaries (up to $173,289 based on training and experience), a high quality of life, and career enhancement opportunities. For more information on CSH and to apply for this position, please visit our website: www.csh.dmhmrsas.virginia.gov EEO/AA

Central State Hospital
26317 W. Washington Street
Petersburg, VA 23803
p: 804-524-4451/7111
e: employment@csh.dmhmrsas.virginia.gov

Chair, Addictions Psychiatry

The Department of Psychiatry, Medical College of Virginia at Virginia Commonwealth University, in collaboration with VCU Institute for Drug and Alcohol Studies, is recruiting a strong academic leader to chair the Division of Addiction Psychiatry. Doctoral level applicant should have career commitment to addictions research and a track record of research/funding. Responsible for developing teaching and clinical programs needed to support teaching/research. Resources available to support an expanded research program. Funded ACGME accredited Fellowship Program. We have strong programs in psychiatric genetics, epidemiology, pharmacology, toxicology, and women's health. Laboratory and community based research are active areas for collaboration. New Dean is a strong supporter of psychiatric research. Department of Psychiatry has over 85 full-time faculty, 38 residents, multiple fellowships and research centers. VCU is a large urban university with robust health science campus and 750-bed university hospital. Richmond, the State Capital, has moderate climate, a rich history, cultural activities, excellent choices for urban, suburban, or country living, outstanding public/private schools. See comparative cost of living via Internet at www.coli.org/. Virginia Commonwealth University is an Equal Opportunity/Affirmative Action employer. Women, persons with disabilities, and minorities are encouraged to apply. Send applications to Joel J. Silverman, M.D., Chairman, c/o Marie Baker-Roach, Department of Psychiatry, MCV/VCU Box 980710, Richmond, VA 23298.

Virginia Licensed Psychiatrist to join a large multi-disciplinary group of providers w/ several locations in the Virginia Beach area. Excellent compensation & benefits. Fax Resume to: Christian Psychotherapy Service, 757-497-1327 or call 757-490-0377.

WASHINGTON

Western Washington State: Adult/Geriatric/Forensic Psychiatrist (BE/BC with a WA state license) applications considered. Western State Hospital is a fully accredited (JCAHO) and certified (CMS) 997 bed hospital serving adult, geriatric and forensic populations. Annual salary up to $158,304 DOQ. Excellent benefits, including hospitalization/medical insurance, retirement and vacation leave, plus optional deferred income plan. Send CV to Norma Jones, Medical Staff Coordinator; Western State Hospital; 9601 Steilacoom Blvd. SW; Lakewood, WA 98498-7213. E-Mail: JONESNL2@DSHS.WA.GOV.

WISCONSIN

Adult Psychiatrists

Child and Adolescent Psychiatrists

The University of Wisconsin Department of Psychiatry is seeking BC/BE Child and Adolescent Psychiatrists and BC/BE Adult Psychiatrists to join our expanding clinical and research programs. Primary responsibilities include outpatient or inpatient clinical care, supervision of residents, and teaching of medical students and residents. Administrative and research experience is highly valued. Candidates will also have the opportunity to participate in collaborative and independent research within a Department nationally recognized for excellence in developmental and emotions research.

Please send letter of interest and your CV to:

Jeff Charlson
Department Administrator
University of Wisconsin School of Medicine and Public Health
Department of Psychiatry
6001 Research Park Boulevard
Madison, WI 53719
or via email to jtcharls@wisc.edu

WYOMING

WYOMING: General Psychiatrist. Position duties include covering Inpatient and Outpatient services in a private hospital setting. Salary, benefits and bonus. Join a great staff & stable physician team. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

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Fellowships

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Geriatric Psychiatry Fellowship

The Department of Psychiatry of the State University of Buffalo School of Medicine and Biomedical Sciences (SMBS) has openings for two ACGME-accredited PGY 5 Geriatric Psychiatry fellows to begin July 2008. The fellows will participate in a clinical milieu emphasizing understanding the psychiatric aspects of medical conditions along with the medical aspects of psychiatric conditions in the elderly. Rotations will include: Geriatrics, Neurology, Hospice, Day Rehabilitation, Home Health Care, SNF, Inpatient, Outpatient, C/L and Telepsychiatry. Fellows will have the unusual opportunity through collaborative consultation-liaison work to develop clinical expertise and professional relationship skills working closely with trainees and faculty in geriatric medicine and neurology. They will participate in a comprehensive didactic program in preparation for the ABPN geriatric psychiatry certification. Assistance and collaboration with a scholarly effort will be available during the year.
Please submit your CV, your letter of interest, three letters of reference including one from your residency training program director, state licenses and any Board or certification exams you have passed to:

Sandra Gilliam
Program Coordinator
Office of Graduate Medical Education
462 Grider St
Buffalo, NY 14215
(716) 961-6955
(716) 961-6960 fax
gilliam3@buffalo.edu

Marion Zucker Goldstein, MD
Professor of Psychiatry
Division and Program Director Geriatric Psychiatry Fellowship
ECMC Department of Psychiatry
462 Grider St.
Buffalo, NY 14215
(716) 898-3630
mzg@buffalo.edu

Steven Dubovsky, MD
Chair and Professor of Psychiatry
dubovsky@buffalo.edu

PSYCHOSOMATIC MEDICINE FELLOWSHIPS 7/08-6/09 NY Medical College/Westchester Medical Center

Established C/L Group in tertiary care hospital. 45 minutes from NYC. Opportunity to work in Burn, High-Risk OB, HIV, Transplant as well as General Med/Surg. Research opportunities. Psychiatry residency & NYS limited permit or license required. Competitive salary and benefits. Contact: Yvette Smolin, MD, Training Director, BHC Room N301, Valhalla, NY 10595 (914) 493-8424 y.smolin@worldnet.att.net

Psychiatry Fellowships

Virginia Commonwealth University, Department of Psychiatry is offering ACGME fellowships in Geriatrics, Psychosomatics and Forensics. Competitive salary and allowances. Fellowships offer broad-based training in inpatient/outpatient settings, focusing on acute and chronic disease, consultation services, private evaluations, seminars, research and teaching experiences. Applicants must demonstrate good communication skills, and have completed approved residency in psychiatry. J-1 applicants eligible. Applications should be sent to Joel Silverman, MD, Chairman, c/o Marie Baker-Roach, Department of Psychiatry, Box 980710, Richmond, VA 23298-0710. Virginia Commonwealth University is Equal Opportunity/Affirmative Action employer and encourages applications from women, minorities, and persons with disabilities.

INFANT PSYCHIATRY FELLOWSHIP. The Section of Child and Adolescent Psychiatry at Tulane University Health Sciences Center is seeking a full-time Fellow in Infant Psychiatry. This one or two year fellowship includes clinical and research experiences with the multidisciplinary Infant Mental Health group at Tulane. Completion of a fellowship in Child and Adolescent Psychiatry preferred. Faculty appointment at the Instructor level is possible. Applications will be accepted until a suitable qualified candidate is found. Applicants should send letter of interest, updated CV and list references to Charles Zeanah, MD, Vice Chair and Director of Child and Adolescent Psychiatry, 1440 Canal Street TB52, New Orleans, LA 70112. Interested eligible applicants may obtain further information regarding this position by contacting Dr. Zeanah at 504-988-5402 or czeanah@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.

Geriatric Psychiatry Fellowship Training University of Rochester Medical Center Rochester, NY

The University of Rochester Medical Center is a nationally recognized center for excellence in geriatric psychiatry along with allied fields including neurobiology and aging, gerontology, and geriatric medicine. Since 1983, we have offered fellowship training in geriatric psychiatry as part of a rich educational tradition in multidisciplinary, clinical and academic activities.

We offer one-year PGY-5 clinical fellowships in geriatric psychiatry. Upon successful completion of our ACGME-accredited program, our graduates will be eligible for the ABPN subspecialty examination in geriatric psychiatry.

We also offer a 2-year HRSA-funded Interdisciplinary Geriatrics Fellowship, which integrates the core disciplines of psychiatry, medicine, and dentistry, and prepares trainees for careers in academic medicine as clinical and educational leaders.

Both fellowships offer training in the care of older patients in a variety of inpatient, long-term care, outpatient, consultation, and palliative care settings. Supervised clinical experiences are complemented by a didactic program, elective offerings, and opportunities to develop individual scholarly and research interests. In addition to the breadth of our clinical programs and patient populations, we have a large cadre of experienced and nationally recognized clinicians, teachers, and researchers serving on our faculty. We pride ourselves on providing a stimulating, rewarding educational experience in a supportive and nurturing environment.

For more information please contact:
Jeffrey M. Lyness, MD
Director, Geriatric Psychiatry
Fellowship Program
University of Rochester Medical Center
Phone: 585.275.6741
Email: Jeffrey_Lyness@urmc.rochester.edu
Or visit our website at:
www.urmc.rochester.edu/smd/psych/educ_train/fellowship/geriatrics/index.cfm

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PSYCHOSOMATIC MEDICINE FELLOWSHIP UNIVERSITY OF MICHIGAN

A Psychosomatic Medicine fellowship position is available at the University of Michigan, Department of Psychiatry. The one-year fellowship program (PGY-5) provides a broad-based clinical experience, with a strong multidisciplinary emphasis, and opportunities to achieve skills in research, education and administration, in an extraordinarily rich academic environment, with no night or weekend on-call. Supervision is provided by full-time attendings with board certification in Psychosomatic Medicine. The fellowship begins on July 1, 2008. Excellent salary and benefits. Candidates must have completed an approved residency in Psychiatry and must have passed USMLE Step III prior to entry into program.

Applications will be accepted through January 15, 2008. Please email/mail/fax CV to Michelle Riba, MD, Associate Director, Psychosomatic Medicine Services, Department of Psychiatry, University of Michigan Health System, 1500 E. Medical Center Drive, Room F6236 MCHC, Ann Arbor, MI, 48109-0295. Tel: (734) 764-6879; FAX: (734) 936-1130; web: http://www.med.umich.edu/psych/education, Email: gacioch@umich.edu.

Psychosomatic Medicine Fellowship, Portland, Oregon. Recruiting for 07/01/08 ACGME -accredited PGY5 level, at Oregon Health & Science Univ and Portland VA Med Center. Flexible program with clinical and research opportunities. Training sites include ambulatory care, specialty services, and consultation to inpatient med/surg. Research and clinical strengths in health services, mental disorders in primary care, pain, end-of-life/palliative care, ethics, mood disorders, Parkinson's disease, and substance abuse. Contact Dr. Steve Dobscha, Portland VA Med. Ctr., PO Box 1034 (R&D 66), Portland, OR 97207; (503) 220-8262, Ext. 156444; or at steven.dobscha@va.gov. EOE.

Geriatric Psychiatry Fellowship with Emphasis on Integrated Consultation-Liaison Psychiatry

Stony Brook University's Department of Psychiatry and Behavioral Science announces the availability of an innovative ACGME-accredited geriatric psychiatry fellowship position starting July 2008 with the option for special emphasis on consultation-liaison psychiatry. With eight board-certified geriatric psychiatrists on the faculty, the geriatric psychiatry fellow will have dedicated experiences in geriatric inpatient, long-term care, outpatient, ECT, and consultation-liaison psychiatry at both the University Hospital as well as several community settings. Located within the new Stony Brook Division of Medical and Geriatric Psychiatry, fellows in geriatric psychiatry will participate in a clinical milieu emphasizing understanding the psychiatric aspects of medical conditions along with the medical aspects of psychiatric conditions. Fellows have the unusual opportunity through collaborative consultation-liaison work to develop added clinical expertise and professional relationship skills working closely with trainees and faculty in geriatric medicine, neurology, and family medicine. To apply for the position send by U.S. mail, fax (631) 444-7534, or e-mail *steven.cole@stonybrook.edu* your letter of interest, your CV, and three letters of reference to Steven Cole, M.D., Head, Division of Medical and Geriatric Psychiatry Health Sciences Center, 10th Floor, Room 042, Stony Brook NY 11794-8101. Equal opportunity/affirmative action employer. Visit *www.stonybrook.edu/jobs* for employment information.

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WARNING

Suicidality and Antidepressant Drugs-Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Cymbalta or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Cymbalta is not approved for use in pediatric patients.

INDICATIONS AND USAGE: Cymbalta is indicated for the: treatment of major depressive disorder (MDD); the management of neuropathic pain associated with diabetic peripheral neuropathy (DPN); treatment of generalized anxiety disorder (GAD).

CONTRAINDICATIONS: ***Hypersensitivity***—Known hypersensitivity to duloxetine or any of the inactive ingredients. ***Monoamine Oxidase Inhibitors (MAOIs)***—Concomitant use with Cymbalta is contraindicated (*see* WARNINGS). ***Uncontrolled Narrow-Angle Glaucoma***—In clinical trials, Cymbalta use was associated with an increased risk of mydriasis; therefore, its use is not recommended in patients with uncontrolled narrow-angle glaucoma.

WARNINGS: Clinical Worsening and Suicide Risk—Patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide. There has been a long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment.

Pooled analyses of short-term placebo-controlled trials of antidepressant drugs (SSRIs and others) showed that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18-24) with major depressive disorder (MDD) and other psychiatric disorders. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction with antidepressants compared to placebo in adults aged 65 and older.

The pooled analyses of placebo-controlled trials in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4400 patients. The pooled analyses of placebo-controlled trials in adults with MDD or other psychiatric disorders included a total of 295 short-term trials (median duration of 2 months) of 11 antidepressant drugs in over 77,000 patients. There was considerable variation in risk of suicidality among drugs, but a tendency toward an increase in the younger patients for almost all drugs studied. There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD. The risk of differences (drug vs placebo), however, were relatively stable within age strata and across indications. These risk differences (drug-placebo difference in the number of cases of suicidality per 1000 patients treated) are provided in Table 1.

Table 1

Age Range	Drug-Placebo Difference in Number of Cases of Suicidality per 1000 Patients Treated
	Increases Compared to Placebo
<18	14 additional cases
18-24	5 additional cases
	Decreases Compared to Placebo
25-64	1 fewer case
≥65	6 fewer cases

No suicides occurred in any of the pediatric trials. There were suicides in the adult trials, but the number was not sufficient to reach any conclusion about drug effect on suicide.

It is unknown whether the suicidality risk extends to longer-term use, i.e., beyond several months. However, there is substantial evidence from placebo-controlled maintenance trials in adults with depression that the use of antidepressants can delay the recurrence of depression.

All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for MDD as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality.

Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms.

If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms (*see* PRECAUTIONS, Discontinuation of Treatment with Cymbalta).

Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers. Such monitoring should include daily observation by families and caregivers. Prescriptions for Cymbalta should be written for the smallest quantity of capsules consistent with good patient management, in order to reduce the risk of overdose.

Screening Patients for Bipolar Disorder—A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. It should be noted that Cymbalta (duloxetine) is not approved for use in treating bipolar depression.

MAOIs—In patients receiving a serotonin reuptake inhibitor (SSRI) in combination with an MAOI, there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued SSRIs and are then started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. The effects of combined use of Cymbalta and MAOIs have not been evaluated in humans or animals. Therefore, because Cymbalta is an inhibitor of both serotonin and norepinephrine reuptake, it is recommended that Cymbalta not be used in combination with an MAOI, or within at least 14 days of discontinuing treatment with an MAOI. Based on the half-life of Cymbalta, at least 5 days should be allowed after stopping Cymbalta before starting an MAOI.

Serotonin Syndrome—The development of a potentially life-threatening serotonin syndrome may occur with SNRIs and SSRIs, including Cymbalta treatment, particularly with concomitant use of serotonergic drugs (including triptans) and with drugs which impair metabolism of serotonin (including MAOIs). Serotonin syndrome symptoms may include mental status changes (eg, agitation, hallucinations, coma), autonomic instability (eg, tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (eg, hyperreflexia, incoordination) and/or gastrointestinal symptoms (eg, nausea, vomiting, diarrhea).

The concomitant use of Cymbalta with MAOIs intended to treat depression is contraindicated (*see* CONTRAINDICATIONS *and* WARNINGS, Potential for Interaction with MAOIs).

If concomitant treatment of Cymbalta with a 5-hydroxytryptamine receptor agonist (triptan) is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (*see* PRECAUTIONS, Drug Interactions).

The concomitant use of Cymbalta with serotonin precursors (such as tryptophan) is not recommended (*see* PRECAUTIONS, Drug Interactions).

PRECAUTIONS: ***General***—Hepatotoxicity—Cymbalta increases the risk of elevation of serum transaminase levels. Liver transaminase elevations resulted in the discontinuation of 0.4% (31/8454) of Cymbalta-treated patients. In these patients, the median time to detection of the transaminase elevation was about two months. In controlled trials in MDD, elevations of alanine transaminase (ALT) to >3 times the upper limit of normal occurred in 0.9% (8/930) of Cymbalta-treated patients and in 0.3% (2/652) of placebo-treated patients. In controlled trials in DPN, elevations of ALT to >3 times the upper limit of normal occurred in 1.68% (8/477) of Cymbalta-treated patients and in 0% (0/187) of placebo-treated patients. In the full cohort of placebo-controlled trials in any indication, elevation of ALT > 3 times the upper limit of normal occurred in 1% (39/3732) of Cymbalta-treated patients compared to 0.2% (6/2568) of placebo-treated patients. In placebo-controlled studies using a fixed-dose design, there was evidence of a dose-response relationship for ALT and AST elevation of >3 times the upper limit of normal and >5 times the upper limit of normal, respectively. Postmarketing reports have described cases of hepatitis with abdominal pain, hepatomegaly and elevation of transaminase levels to more than twenty times the upper limit of normal with or without jaundice, reflecting a mixed or hepatocellular pattern of liver injury. Cases of cholestatic jaundice with minimal elevation of transaminase levels have also been reported.

The combination of transaminase elevations and elevated bilirubin, without evidence of obstruction, is generally recognized as an important predictor of severe liver injury. In clinical trials, three Cymbalta patients had elevations of transaminases and bilirubin, but also had elevation of alkaline phosphatase, suggesting an obstructive process; in these patients, there was evidence of heavy alcohol use and this may have contributed to the abnormalities seen. Two placebo-treated patients also had transaminase elevations with elevated bilirubin. Postmarketing reports indicate that elevated transaminases, bilirubin and alkaline phosphatase have occurred in patients with chronic liver disease or cirrhosis. Because it is possible that duloxetine and alcohol may interact to cause liver injury or that duloxetine may aggravate pre-existing liver disease, Cymbalta should ordinarily not be prescribed to patients with substantial alcohol use or evidence of chronic liver disease. Orthostatic Hypotension and Syncope—Orthostatic hypotension and syncope have been reported with therapeutic doses of duloxetine. Syncope and orthostatic hypotension tend to occur within the first week of therapy but can occur at any time during duloxetine treatment, particularly after dose increases. The risk of blood pressure decreases may be greater in patients taking concomitant medications that induce orthostatic hypotension (such as antihypertensives) or are potent CYP1A2 inhibitors (*see* CLINICAL PHARMACOLOGY, Drug-Drug Interactions, *and* PRECAUTIONS, Drug Interactions) and in patients taking duloxetine at doses above 60 mg daily. Consideration should be given to discontinuing duloxetine in patients who experience symptomatic orthostatic hypotension and/or syncope during duloxetine therapy. Effect on Blood Pressure—In clinical trials across indications, relative to placebo, duloxetine treatment was associated with mean increases of up to 2.1 mm Hg in systolic blood pressure and up to 2.3 mm Hg in diastolic blood pressure. There was no significant difference in the frequency of sustained (3 consecutive visits) elevated blood pressure. In a clinical pharmacology study designed to evaluate the effects of duloxetine on various parameters, including blood pressure at supratherapeutic doses with an accelerated dose titration, there was evidence of increases in supine blood pressure at doses up to 200 mg BID. At the highest 200 mg BID dose, the increase in mean pulse rate was 5.0-6.8 bpm and increases in mean blood pressure were 4.7-6.8 mm Hg (systolic) and 4.5-7 mm Hg (diastolic) up to 12 hours after dosing. Blood pressure should be measured prior to initiating treatment and periodically measured throughout treatment (*see* ADVERSE REACTIONS, Vital Sign Changes). Activation of Mania/Hypomania—In placebo-controlled trials in patients with MDD, activation of mania or hypomania was reported in 0.1% (2/2327) of duloxetine-treated patients and 0.1% (1/1460) of placebo-treated patients. No activation of mania or hypomania was reported in DPNP or GAD placebo-controlled trials. Activation of mania/hypomania has been reported in a small proportion of patients with mood disorders who were treated with other marketed drugs effective in the treatment of MDD. As with these other agents, Cymbalta should be used cautiously in patients with a history of mania. Seizures—Duloxetine has not been systematically evaluated in patients with a seizure disorder, and such patients were excluded from clinical studies. In placebo-controlled clinical trials, seizures/convulsions occurred in 0.04% (3/8504) of patients treated with duloxetine and 0.02% (1/6123) of placebo-treated patients. Cymbalta should be prescribed with care in patients with a history of a seizure disorder. Hyponatremia—Cases of hyponatremia (some with serum sodium lower than 110 mmol/L) have been reported and appeared to be reversible when Cymbalta was discontinued. Some cases were possibly due to the syndrome of inappropriate antidiuretic hormone secretion (SIADH). The majority of these occurrences have been in elderly individuals, some in patients taking diuretics or who were otherwise volume depleted. Controlled Narrow-Angle Glaucoma—In clinical trials, Cymbalta was associated with an increased risk of mydriasis; therefore, it should be used cautiously in patients with controlled narrow-angle glaucoma (*see* CONTRAINDICATIONS, Uncontrolled Narrow-Angle Glaucoma). Discontinuation of Treatment with Cymbalta—Discontinuation symptoms have been systematically evaluated in patients taking duloxetine. Following abrupt discontinuation in placebo-controlled clinical trials, the following symptoms occurred at a rate greater than or equal to 1% and at a significantly higher rate in duloxetine-treated patients compared to those discontinuing from placebo: dizziness; nausea; headache; paresthesia; vomiting; irritability; nightmares; insomnia; diarrhea; anxiety; hyperhidrosis; and vertigo.

During marketing of other SSRIs and SNRIs (serotonin and norepinephrine reuptake inhibitors), there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (eg, paresthesias such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia, hypomania, tinnitus, and seizures. Although these events are generally self-limiting, some have been reported to be severe.

Patients should be monitored for these symptoms when discontinuing treatment with Cymbalta. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate.

Use in Patients with Concomitant Illness—Clinical experience with Cymbalta in patients with concomitant systemic illnesses is limited. There is no information on the effect that alterations in gastric motility may have on the stability of Cymbalta's enteric coating. As duloxetine is rapidly hydrolyzed in acidic media to naphthol, caution is advised in using Cymbalta in patients with conditions that may slow gastric emptying (eg, some diabetics). Cymbalta has not been systematically evaluated in patients with a recent history of myocardial infarction or unstable coronary artery disease. Patients with these diagnoses were generally excluded from clinical studies during the product's premarketing testing. As observed in DPNP trials, Cymbalta treatment worsens glycemic control in some patients with diabetes. In three clinical trials of Cymbalta for the management of neuropathic pain associated with diabetic peripheral neuropathy, the mean duration of diabetes was approximately 12 years, the mean baseline fasting blood glucose was 176 mg/dL, and the mean baseline hemoglobin A_{1c} (HbA_{1c}) was 7.8%. In the 12-week acute treatment phase of these studies, Cymbalta was associated with a small increase in mean fasting blood glucose as compared to placebo. In the extension phase of these studies, which lasted up to 52 weeks, mean fasting blood glucose increased by 12 mg/dL in the Cymbalta group and decreased by 11.5 mg/dL in the routine care group. HbA_{1c} increased by 0.5% in the Cymbalta and by 0.2% in the routine care groups. Increased plasma concentrations of duloxetine, and especially of its metabolites, occur in patients with end-stage renal disease (requiring dialysis). For this reason, Cymbalta is not recommended for patients with end-stage renal disease or severe renal impairment (creatinine clearance <30 mL/min). Markedly increased exposure to duloxetine occurs in patients with hepatic insufficiency and Cymbalta should not be administered to these patients.

Laboratory Tests—No specific laboratory tests are recommended.

Drug Interactions—*Potential for Other Drugs to Affect Cymbalta*—Both CYP1A2 and CYP2D6 are responsible for duloxetine metabolism. Inhibitors of CYP1A2—Concomitant use of duloxetine with fluvoxamine, an inhibitor of CYP1A2, results in approximately a 6-fold increase in AUC and about a 2.5-fold increase in C_{max} of duloxetine. Some quinolone antibiotics would be expected to have similar effects and these combinations should be avoided. Inhibitors of CYP2D6—Because CYP2D6 is involved in duloxetine metabolism, concomitant use of duloxetine with potent inhibitors of CYP2D6 may result in higher concentrations of duloxetine. Paroxetine (20 mg QD) increased the concentration of duloxetine (40 mg QD) by about 60%, and greater degrees of inhibition are expected with higher doses of paroxetine. Similar effects would be expected with other potent CYP2D6 inhibitors (eg, fluoxetine, quinidine). *Potential for Duloxetine to Affect Other Drugs*—Drugs Metabolized by CYP1A2—*In vitro* drug interaction studies demonstrate that duloxetine does not induce CYP1A2 activity, and it is unlikely to have a clinically significant effect on the metabolism of CYP1A2 substrates. Drugs Metabolized by CYP2D6—Cymbalta is a moderate inhibitor of CYP2D6. When duloxetine was administered (at a dose of 60 mg BID) in conjunction with a single 50-mg dose of desipramine, a CYP2D6 substrate, the AUC of desipramine increased 3-fold. Therefore, co-administration of Cymbalta with other drugs that are extensively metabolized by this isozyme and which have a narrow therapeutic index, including certain antidepressants (tricyclic antidepressants [TCAs], such as nortriptyline, amitriptyline, and imipramine), phenothiazines and Type 1C antiarrhythmics (eg, propafenone, flecainide), should be approached with caution. Plasma TCA concentrations may need to be monitored and the dose of the TCA may need to be reduced if a TCA is co-administered with Cymbalta. Because of the risk of serious ventricular arrhythmias and sudden death potentially associated with elevated plasma levels of thioridazine, Cymbalta and thioridazine should not be co-administered. Drugs Metabolized by CYP3A—Results of *in vitro* studies demonstrate that duloxetine does not inhibit or induce CYP3A activity. *Cymbalta May Have a Clinically Important Interaction with the Following Other Drugs*—Alcohol—When Cymbalta and ethanol were administered several hours apart so that peak concentrations of each would coincide, Cymbalta did not increase the impairment of mental and motor skills caused by alcohol. In the Cymbalta clinical trials database, three Cymbalta-treated patients had liver injury as manifested by ALT and total bilirubin elevations, with evidence of obstruction. Substantial intercurrent ethanol use was present in each of these cases, and this may have contributed to the abnormalities seen (*see* PRECAUTIONS, Hepatotoxicity). CNS-Acting Drugs—Given the primary CNS effects of Cymbalta, it should be used with caution when it is taken in combination with or substituted for other centrally acting drugs, including those with a similar mechanism of action. Serotonergic Drugs—Based on the mechanism of action of SNRIs and SSRIs, including Cymbalta and the potential for serotonin syndrome, caution is advised when Cymbalta is coadministered with other drugs that may affect the serotonergic neurotransmitter systems, such as triptans, linezolid (an antibiotic which is a reversible non-selective MAOI), lithium, tramadol, or St. John's Wort (*see* WARNINGS, Serotonin Syndrome). The concomitant use of Cymbalta with other SSRIs, SNRIs, or tryptophan is not recommended (*see* PRECAUTIONS, Drug Interactions). Triptans—There have been rare postmarketing reports of serotonin syndrome with use of an SSRI and a triptan. If concomitant treatment of Cymbalta with a triptan is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (*see* WARNINGS, Serotonin Syndrome). Potential for Interaction with Drugs that Affect Gastric Acidity—Cymbalta has an enteric coating that resists dissolution until reaching a segment of the gastrointestinal tract where the pH exceeds 5.5. In extremely acidic conditions, Cymbalta, unprotected by the enteric coating, may undergo hydrolysis to form naphthol. Caution is advised in using Cymbalta in patients with conditions that may slow gastric emptying (eg, some diabetics). Drugs that raise the gastrointestinal pH may lead to an earlier release of duloxetine. However, co-administration of Cymbalta with aluminum- and magnesium-containing antacids (51 mEq) or Cymbalta with famotidine, had no significant effect on the rate or extent of duloxetine absorption after administration of a 40-mg oral dose. It is unknown whether the concomitant administration of proton pump inhibitors affects duloxetine absorption.

Monoamine Oxidase Inhibitors—*See* CONTRAINDICATIONS *and* WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility—Carcinogenesis—Duloxetine was administered in the diet to mice and rats for 2 years. In female mice receiving duloxetine at 140 mg/kg/day (11 times the maximum recommended human dose [MRHD, 60 mg/day] and 6 times the human dose of 120 mg/day on a mg/m^2 basis), there was an increased incidence of hepatocellular adenomas and carcinomas. The no-effect dose was 50 mg/kg/day (4 times the MRHD and 2 times the human dose of 120 mg/day on a mg/m^2 basis). Tumor incidence was not increased in male mice receiving duloxetine at doses up to 100 mg/kg/day (8 times the MRHD and 4 times the human dose of 120 mg/day on a mg/m^2 basis). In rats, dietary doses of duloxetine up to 27 mg/kg/day in females (4 times the MRHD and 2 times the human dose of 120 mg/day on a mg/m^2 basis) and up to 36 mg/kg/day in males (6 times the MRHD and 3 times the human dose of 120 mg/day on a mg/m^2 basis) did not increase the incidence of tumors. Mutagenesis—Duloxetine was not mutagenic in the *in vitro* bacterial reverse mutation assay (Ames test) and was not clastogenic in an *in vivo* chromosomal aberration test in mouse bone marrow cells. Additionally, duloxetine was not genotoxic in an *in vitro* mammalian forward gene mutation assay in mouse lymphoma cells or in an *in vitro* unscheduled DNA synthesis (UDS) assay in primary rat hepatocytes, and did not induce sister chromatid exchange in Chinese hamster bone marrow *in vivo*. Impairment of Fertility—Duloxetine administered orally to either male or female rats prior to and throughout mating at daily doses up to 45 mg/kg/day (7 times the maximum recommended human dose of 60 mg/day and 4 times the human dose of 120 mg/day on a mg/m^2 basis) did not alter mating or fertility.

Pregnancy—Pregnancy Category C—In animal reproduction studies, duloxetine has been shown to have adverse effects on embryo/fetal and postnatal development. When duloxetine was administered orally to pregnant rats and rabbits during the period of organogenesis, there was no evidence of teratogenicity at doses up to 45 mg/kg/day (7 times the maximum recommended human dose [MRHD, 60 mg/day] and 4 times the human dose of 120 mg/day on a mg/m^2 basis, in rats; 15 times the MRHD and 7 times the human dose of 120 mg/day on a mg/m^2 basis in rabbits). However, fetal weights were decreased at this dose, with a no-effect dose of 10 mg/kg/day (2 times the MRHD and =1 times the human dose of 120 mg/day on a mg/m^2 basis in rats; 3 times the MRHD and 2 times the human dose of 120 mg/day on a mg/m^2 basis in rabbits). When duloxetine was administered orally to pregnant rats throughout gestation and lactation, the survival of pups to 1 day postpartum and pup body weights at birth and during the lactation period were decreased at a dose of 30 mg/kg/day (5 times the MRHD and 2 times the human dose of 120 mg/day on a mg/m^2 basis); the no-effect dose was 10 mg/kg/day. Furthermore, behaviors consistent with increased reactivity, such as increased startle response to noise and decreased habituation of locomotor activity, were observed in pups following maternal exposure to 30 mg/kg/day. Post-weaning growth and reproductive performance of the progeny were not affected adversely by maternal duloxetine treatment.

There are no adequate and well-controlled studies in pregnant women; therefore, duloxetine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects—Neonates exposed to SSRIs or serotonin and norepinephrine reuptake inhibitors (SNRIs), late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome (*see* WARNINGS, Monoamine Oxidase Inhibitors). When treating a pregnant woman with Cymbalta during the third trimester, the physician should carefully consider the potential risks and benefits of treatment.

Labor and Delivery—The effect of duloxetine on labor and delivery in humans is unknown. Duloxetine should be used during labor and delivery only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Duloxetine is excreted into the milk of lactating women. The estimated daily infant dose on a mg/kg basis is approximately 0.14% of the maternal dose. Because the safety of duloxetine in infants is not known, nursing while on Cymbalta is not recommended.

Pediatric Use—Safety and effectiveness in the pediatric population have not been established (*see* BOX WARNING *and* WARNINGS, Clinical Worsening and Suicide Risk). Anyone considering the use of Cymbalta in a child or adolescent must balance the potential risks with the clinical need.

Geriatric Use—Of the 2418 patients in premarketing clinical studies of Cymbalta for MDD, 5.9% (143) were 65 years of age or over. Of the 1074 patients in the DPN premarketing studies, 33% (357) were 65 years of age or over. Premarketing clinical studies of GAD did not include sufficient numbers of subjects age 65 or over to determine whether they respond differently from younger subjects. In the MDD and DPN studies, no overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. As with other antidepressants, Cymbalta has been associated with cases of clinically significant hyponatremia (*see* Hyponatremia, *under* PRECAUTIONS).

ADVERSE REACTIONS: Cymbalta has been evaluated for safety in 2418 patients diagnosed with MDD who participated in multiple-dose premarketing trials, representing 1099 patient-years of exposure. Among these 2418 Cymbalta-treated patients, 1139 patients participated in eight 8 or 9 week, placebo-controlled trials at doses ranging from 40 to 120 mg/day, while the remaining 1279 patients were followed for up to 1 year in an open-label safety study using flexible doses from 80 to 120 mg/day. Two placebo-controlled studies with doses of 80 and 120 mg/day had 6-month maintenance extensions. Of these 2418 patients, 993 Cymbalta-treated patients were exposed for at least 180 days and 445 Cymbalta-treated patients were exposed for at least 1 year. Cymbalta has also been evaluated for safety in 1074 patients with diabetic peripheral neuropathy representing 472 patient-years of exposure. Among these 1074 Cymbalta-treated patients, 568 patients participated in two 12 to 13 week, placebo-controlled trials at doses ranging from 20 to 120 mg/day. An additional 449 patients were enrolled in an open-label safety study using 120 mg/day for a duration of 6 months. Another 57 patients, originally treated with placebo, were exposed to Cymbalta for up to 12 months at 60 mg twice daily in an extension phase. Among these 1074 patients, 484 had 6 months of exposure to Cymbalta, and 220 had 12 months of exposure.

Cymbalta has also been evaluated for safety in 668 patients with GAD representing 95 patient-years of exposure. These 668 patients participated in 9- or 10-week placebo-controlled trials at doses ranging from 60 to 120 mg once daily. Of these 668 patients, 449 were exposed for at least 2 months to Cymbalta.

In the full cohort of placebo-controlled clinical trials for any indication, safety has been evaluated in 8504 patients treated with duloxetine and 6123 patients treated with placebo. In clinical trials, a total of 23,983 patients have been exposed to duloxetine. In duloxetine clinical trials, adverse reactions were assessed by collecting adverse events, results of physical examinations, vital signs, weights, laboratory analyses, and ECGs.

Clinical investigators recorded adverse events using descriptive terminology of their own choosing. To provide a meaningful estimate of the proportion of individuals experiencing adverse events, grouping similar types of events into a smaller number of standardized event categories is necessary. MedDRA terminology was used to classify reported adverse events.

The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. Events reported during the studies were not necessarily caused by the therapy, and the frequencies do not reflect investigator impression (assessment) of causality.

Adverse Events Reported as Reasons for Discontinuation of Treatment in Placebo-Controlled Trials—Major Depressive Disorder—Approximately 10% of the 1139 patients who received Cymbalta in the MDD placebo-controlled trials discontinued treatment due to an adverse event, compared with 4% of the 777 patients receiving placebo. Nausea (Cymbalta 1.4%, placebo 0.1%) was the only common adverse event reported as reason for discontinuation and considered to be drug-related (ie, discontinuation occurring in at least 1% of the Cymbalta-treated patients and at a rate of at least twice that of placebo). Diabetic Peripheral Neuropathic Pain—Approximately 14% of the 568 patients who received Cymbalta in the DPN placebo-controlled trials discontinued treatment due to an adverse event, compared with 7% of the 223 patients receiving placebo. Nausea (Cymbalta 3.5%, placebo 0.4%), dizziness (Cymbalta 1.6%, placebo 0.4%), somnolence (Cymbalta 1.6%, placebo 0%) and fatigue (Cymbalta 1.1%, placebo 0%) were the common adverse events reported as reasons for discontinuation and considered to be drug-related (ie, discontinuation occurring in at least 1% of the Cymbalta-treated patients and at a rate of at least twice that of placebo). Generalized Anxiety Disorder—Approximately 16% of the 668 patients who received Cymbalta in the GAD placebo-controlled trials discontinued treatment due to an adverse event, compared with 4% of the 495 patients receiving placebo. Nausea (Cymbalta 3.7%, placebo 0.2%), vomiting (Cymbalta 1.4%, placebo 0%), and dizziness (Cymbalta 1.2%, placebo 0.2%) were the common adverse events reported as reasons for discontinuation and considered to be drug-related (ie, discontinuation occurring in at least 1% of the Cymbalta-treated patients and at a rate of at least twice that of placebo).

Adverse Events Occurring at an Incidence of 2% or More Among Cymbalta-Treated Patients in Placebo-Controlled Trials—Major Depressive Disorder—Treatment-emergent adverse events that occurred in 2% or more of patients treated with Cymbalta in the premarketing acute phase of MDD placebo-controlled trials (N=1139 Cymbalta; N=777 placebo) with an incidence greater than placebo were: Gastrointestinal Disorders—nausea, dry mouth, constipation, diarrhea, vomiting; Metabolism and Nutrition Disorders—appetite decreased (includes anorexia); Investigations—weight decreased; General Disorders and Administration Site Conditions—fatigue; Nervous System Disorders—dizziness, somnolence, tremors; Skin and Subcutaneous Tissue Disorders—sweating increased; Vascular Disorders—hot flushes; Eye Disorders—vision blurred; Psychiatric Disorders—insomnia (includes middle insomnia), anxiety, libido decreased, orgasm abnormal (includes anorgasmia); Reproductive System and Breast Disorders—males only: erectile dysfunction, ejaculation delayed, ejaculatory dysfunction (includes ejaculation disorder and ejaculation failure).

The following events were reported by at least 2% of patients treated with Cymbalta for MDD and had an incidence ≤ placebo: upper abdominal pain, palpitations, dyspepsia, back pain, arthralgia, headache, pharyngitis, cough, nasopharyngitis, and upper respiratory tract infection.

The most commonly observed adverse events in Cymbalta-treated MDD patients (incidence ≥5% and at least twice the incidence in placebo patients) were: nausea; dry mouth; constipation; decreased appetite; fatigue; somnolence; and increased sweating.

Diabetic Peripheral Neuropathic Pain—Treatment-emergent adverse events that occurred in 2% or more of patients treated with Cymbalta in the premarketing acute phase of DPN placebo-controlled trials (N=225 Cymbalta 60 mg BID; N=228 Cymbalta 60 mg QD; N=115 Cymbalta 20 mg QD; N=223 placebo) with an incidence greater than placebo were: Gastrointestinal Disorders—nausea, constipation, diarrhea, dry mouth, vomiting, dyspepsia, loose stools; General Disorders and Administration Site Conditions—fatigue, asthenia, pyrexia; Infections and Infestations—nasopharyngitis; Metabolism and Nutrition Disorders—decreased appetite, anorexia; Musculoskeletal and Connective Tissue Disorders—muscle cramp, myalgia; Nervous System Disorders—somnolence, headache, dizziness, tremor; Psychiatric Disorders—insomnia; Renal and Urinary Disorders—pollakiuria; Reproductive System and Breast Disorders—erectile dysfunction; Respiratory, Thoracic and Mediastinal Disorders—cough, pharyngolaryngeal pain; Skin and Subcutaneous Tissue Disorders—hyperhidrosis.

The following events were reported by at least 2% of patients treated with Cymbalta for DPN and had an incidence ≤ placebo: edema peripheral, influenza, upper respiratory tract infection, back pain, arthralgia, pain in extremity, and pruritus.

The most commonly observed adverse events in Cymbalta-treated DPN patients (incidence ≥5% and at least twice the incidence in placebo patients) were: nausea; somnolence; dizziness; constipation; dry mouth; hyperhidrosis; decreased appetite; and asthenia.

Generalized Anxiety Disorder—Treatment-emergent adverse events that occurred in 2% or more of patients treated with Cymbalta in the premarketing acute phase of GAD placebo-controlled trials (doses of 60-120 mg once daily) (N=668 Cymbalta; N=495 placebo) and with an incidence greater than placebo were: Eye Disorders—vision blurred; Gastrointestinal Disorders—nausea, dry mouth, constipation, diarrhea, vomiting, abdominal pain, dyspepsia; General Disorders and Administration Site Conditions—fatigue; Metabolism and Nutrition Disorders—appetite decreased; Nervous System Disorders—dizziness, somnolence, tremor, paraesthesia; Psychiatric Disorders—insomnia, libido decreased, agitation, orgasm abnormal; Reproductive System and Breast Disorders—ejaculation delayed, erectile dysfunction; Respiratory, Thoracic and Mediastinal Disorders—yawning; Skin and Subcutaneous Tissue Disorders—hyperhidrosis; Vascular Disorders—hot flushes.

The following events were reported by at least 2% of patients treated with Cymbalta for GAD and had an incidence ≤ placebo: nasopharyngitis, upper respiratory tract infection, heachache, pollakiuria, and musculoskeletal pain (includes myalgia, neck pain).

The most commonly observed adverse events in Cymbalta-treated GAD patients (incidence ≥5% and at least twice the incidence in placebo patients) were: nausea; fatigue; dry mouth; somnolence; constipation; insomnia; appetite decreased; hyperhidrosis; libido decreased; vomiting; ejaculation delayed; and erectile dysfunction.

Adverse events seen in men and women were generally similar except for effects on sexual function (described below). Clinical studies of Cymbalta did not suggest a difference in adverse event rates in people over or under 65 years of age. There were too few non-Caucasian patients studied to determine if these patients responded differently from Caucasian patients.

Effects on Male and Female Sexual Function—Although changes in sexual desire, sexual performance and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling are likely to underestimate their actual incidence. Sexual side effects spontaneously reported by at least 2% of either male or female patients taking Cymbalta in MDD placebo-controlled trials were: Males (N=378 Cymbalta; N=247 placebo): orgasm abnormal (includes anorgasmia), ejaculatory dysfunction (includes ejaculation disorder and ejaculation failure), libido decreased, erectile dysfunction, ejaculation delayed. Females (N=761 Cymbalta; N=530 placebo): orgasm abnormal, libido decreased.

Because adverse sexual events are presumed to be voluntarily underreported, the Arizona Sexual Experience Scale (ASEX), a validated measure designed to identify sexual side effects, was used prospectively in 4 MDD placebo-controlled trials. In these trials, patients treated with Cymbalta experienced significantly more sexual dysfunction, as measured by the total score on the ASEX, than did patients treated with placebo. Gender analysis showed that this difference occurred only in males. Males treated with Cymbalta experienced more difficulty with ability to reach orgasm (ASEX Item 4) than males treated with placebo. Females did not experience more sexual dysfunction on Cymbalta than on placebo as measured by ASEX total score. These studies did not, however, include an active control drug with known effects on female sexual dysfunction, so that there is no evidence that its effects differ from other antidepressants. Physicians should routinely inquire about possible sexual side effects. See Table 5 in full PI for specific ASEX results.

Urinary Hesitation—Cymbalta is in a class of drugs known to affect urethral resistance. If symptoms of urinary hesitation develop during treatment with Cymbalta, consideration should be given to the possibility that they might be drug-related. ***Laboratory Changes***—Cymbalta treatment, for up to 9 weeks in MDD, 9-10 weeks in GAD, or 13 weeks in DPN placebo-controlled clinical trials, was associated with small mean increases from baseline to endpoint in ALT, AST, CPK, and alkaline phosphatase; infrequent, modest, transient, abnormal values were observed for these analytes in Cymbalta-treated patients when compared with placebo-treated patients (*see* PRECAUTIONS). ***Vital Sign Changes***—In clinical trials across indications, relative to placebo, duloxetine treatment was associated with mean increases of up to 2.1 mm Hg in systolic blood pressure and up to 2.3 mm Hg in diastolic blood pressure, averaging up to 2 mm Hg. There was no significant difference in the frequency of sustained (3 consecutive visits) elevated blood pressure (*see* PRECAUTIONS). Duloxetine treatment, for up to 13 weeks in placebo-controlled trials typically caused a small increase in heart rate compared to placebo of up to 3 beats per minute. ***Weight Changes***—In placebo-controlled clinical trials, MDD and GAD patients treated with Cymbalta for up to 10 weeks experienced a mean weight loss of approximately 0.5 kg, compared with a mean weight gain of approximately 0.2 kg in placebo-treated patients. In DPN placebo-controlled clinical trials, patients treated with Cymbalta for up to 13 weeks experienced a mean weight loss of approximately 1.1 kg, compared with a mean weight gain of approximately 0.2 kg in placebo-treated patients. ***Electrocardiogram Changes***—Electrocardiograms were obtained from duloxetine-treated patients and placebo-treated patients in clinical trials lasting up to 13 weeks. No clinically significant differences were observed for QTc, QT, PR, and QRS intervals between duloxetine-treated and placebo-treated patients. There were no differences in clinically meaningful QTcF elevations between duloxetine and placebo. In a positive-controlled study in healthy volunteers using duloxetine up to 200 mg BID, no prolongation of the corrected QT interval was observed.

Postmarketing Spontaneous Reports—Adverse events reported since market introduction that were temporally related to duloxetine therapy and not mentioned elsewhere in labeling include: anaphylactic reaction, angioneurotic edema, erythema multiforme, extrapyramidal disorder, glaucoma, hallucinations, hyperglycemia, hypersensitivity, hypertensive crisis, rash, Stevens-Johnson Syndrome, supraventricular arrhythmia, trismus, and urticaria.

DRUG ABUSE AND DEPENDENCE: ***Controlled Substance Class***—Duloxetine is not a controlled substance. ***Physical and Psychological Dependence***—In animal studies, duloxetine did not demonstrate barbiturate-like (depressant) abuse potential. In drug dependence studies, duloxetine did not demonstrate dependence-producing potential in rats.

While Cymbalta has not been systematically studied in humans for its potential for abuse, there was no indication of drug-seeking behavior in the clinical trials. However, it is not possible to predict on the basis of premarketing experience the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed. Consequently, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of misuse or abuse of Cymbalta (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

OVERDOSAGE: There is limited clinical experience with Cymbalta overdose in humans. In clinical trials, cases of acute ingestions up to 3000 mg, alone or in combination with other drugs, were reported with none being fatal. However, in postmarketing experience, fatal outcomes have been reported for acute overdoses, primarily with mixed overdoses, but also with duloxetine only, at doses as low as approximately 1000 mg. Signs and symptoms of overdose (mostly with mixed drugs) included serotonin syndrome, somnolence, vomiting, and seizures. ***Management of Overdose***—There is no specific antidote to Cymbalta, but if serotonin syndrome ensues, specific treatment (such as with cyproheptadine and/or temperature control) may be considered. In case of acute overdose, treatment should consist of those general measures employed in the management of overdose with any drug.

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Cymbalta® (duloxetine hydrochloride) Delayed-release Capsules PV 5904 AMP
Cymbalta® (duloxetine hydrochloride) Delayed-release Capsules PV 5904 AMP

Milestones reached since coming to market in 2004:

5 million patients

treated in the United States[1]

20 million

prescriptions written[2]

Over 298,000

prescribing physicians[3]

Fastest-growing

antidepressant in 2006[4]
and to date in 2007[5]*

Helping you help your patients, one at a time.

Important Safety Information

- **Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children, adolescents, and young adults with major depressive disorder (MDD) and other psychiatric disorders.**
- **Patients of all ages started on therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.**
- **Cymbalta is not approved for use in pediatric patients.**

Cymbalta should not be used concomitantly with monoamine oxidase inhibitors (MAOIs) or thioridazine and not in patients with a known hypersensitivity or with uncontrolled narrow-angle glaucoma.

Clinical worsening and suicide risk: All patients being treated with an antidepressant for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially within the first few months of treatment and when changing the dose. A health professional should be immediately notified if the depression is persistently worse or there are symptoms that are severe, sudden, or were not part of the patient's presentation. If discontinuing treatment, taper the medication.

Development of a potentially life-threatening serotonin syndrome may occur with SNRIs and SSRIs, including Cymbalta treatment, particularly with concomitant use of serotonergic drugs, including triptans. Concomitant use is not recommended.

Cymbalta should not be administered to patients with any hepatic insufficiency or patients with end-stage renal disease (requiring dialysis) or severe renal impairment (CrCl <30 mL/min).

References: 1. Lilly Global Product Safety, January 2007. **2.** IMS Health, May 2007. **3.** IMS Health, March 2007. **4.** IMS, National Prescription data, January 2007. **5.** IMS, National Prescription data, July 2007.

* Data current as of July 2007.

Postmarketing, severe elevations of liver enzymes or liver injury with a hepatocellular, cholestatic, or mixed pattern have been reported.

Cymbalta should generally not be prescribed to patients with substantial alcohol use or evidence of chronic liver disease.

Cases of orthostatic hypotension and/or syncope as well as cases of hyponatremia have been reported.

As observed in DPNP clinical trials, Cymbalta treatment worsens glycemic control in some patients with diabetes. In the extension phases up to 52 weeks, an increase in HbA_{1c} in both the Cymbalta (0.5%) and routine care groups (0.2%) was noted.

Most common adverse events (≥5% and at least twice placebo) in premarketing clinical trials were:

MDD: nausea, dry mouth, constipation, fatigue, decreased appetite, somnolence, and increased sweating. **DPNP:** nausea, somnolence, dizziness, constipation, dry mouth, increased sweating, decreased appetite, and asthenia. **GAD:** nausea, fatigue, dry mouth, somnolence, constipation, insomnia, appetite decreased, increased sweating, libido decreased, vomiting, ejaculation delayed, and erectile dysfunction.

See Brief Summary of full Prescribing Information, including Boxed Warning, on following page.

Cymbalta® DELAYED RELEASE CAPSULES
duloxetine HCl

Lilly