Welcome Back from Summer Break

Labor Day has passed, children are back to school, vacations are but a memory, days grow gradually shorter as the rhythms of summer shift to a typically more predictable pattern. This year, perhaps more than others in recent past, holds a less predictable pattern for our profession and for all medicine.

One certainty is that we share an unknown future with the advent of many proposed national and local changes to healthcare systems. Some may see a potential practice environment that will allow provision of better patient care within a new healthcare system; some may believe we are on the precipice of pending disaster; while others will be somewhere between these two positions. Change typically brings concerns about the future. Psychiatrists have a critical role to play in the proposed integration of behavioral health and primary care in Massachusetts healthcare reform. MPS has been and will continue to be actively addressing psychiatrist’ practice needs as changes to our healthcare system evolve. I plan to use this column as a medium to inform our members of developments during this time of change.

During the summer, MPS has remained busy in several areas to protect and enhance the position of our membership in several vital ways. MPS leadership, our legislative team, and leaders of our special interests groups have been building or strengthening coalitions to challenge proposals that we feel would adversely affect how we practice and provide patient care and support those that we believe will benefit psychiatry. We have taken action to address serious concerns about the care of our patients. Many of these initiatives remain ongoing and will need updating over the course of the year beyond this summer summary and transition to autumn update.

- A letter to the Boston Globe editor was published in response to an article about unsupervised care provided to psychiatric patients by inadequately trained providers. MPS highlighted the workforce problems due to low reimbursement by behavioral health carve-outs within insurance companies that created a two-tier system with access to quality care for physical health and a lower standard of care and access for behavioral health. This stigmatization and violation of parity is unacceptable.

- MPS Geriatric Psychiatry experts provided testimony to educate members of a legislative subcommittee about the potential adverse impact of proposed bills that would significantly change how we treat geriatric patients who suffer mental illness. Our geriatric group continues to work diligently to provide this expert knowledge to the legislature. We are also developing alliances with other medical professional organizations that share our strong belief that the proposals that legislatures intended to protect vulnerable citizens will have negative unintended consequences, if enacted.

- A group of MPS leaders and experts has been working with other associations including the emergency room physicians to address the long waits our patients sustain in emergency rooms to enter acute inpatient care. While there are many factors that contribute to this problem, some are due to policies that violate parity by mental health insurance carve-outs that seek cost-containment through restrictive requirements such as prior authorizations for acute inpatient care. This coalition was able to shine light on some of the problems that contribute to long emergency room wait for our patients and advance knowledge across disciplines. The group continues to work on solutions to this critical problem.

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Last month Dr. Kathy Sanders, Deputy commissioner for the Department of Mental Health, held a meeting with residents representing different training programs in the state, to talk about our Public Sector Psychiatry experiences. I have to say; it was great seeing such a resident turn out. I appreciated the opportunity to meet with other residents and learn more about their training experiences. The passion, loyalty and commitment shown by residents with every anecdote, and description of their training were remarkable.

The first time I heard the term “Public Sector Psychiatry”, I will admit I was not quite sure what it meant. Although I was familiar with the differences in terms of access to care, I had never stopped to really think about the distinction between private and public sector. I never imagined it would be described as a different entity. Public Psychiatry was previously known as “social” or “community” psychiatry and refers to the treatment of patients in need of social as well as mental health interventions that are supported by government funds. In the past, state hospitals were the main front for these services, but in the last decades there has been a drive for deinstitutionalization, with implementation of community-based programs focusing on a recovery model.

In 2002 President George W. Bush created the New Commission on Mental Health to address obstacles in preventing Americans with mental illness from getting care. Following the commission’s recommendations, the model for mental health treatment focused on recovery, which is described as the focus on the experience of patients and how to help individuals achieve optimal functioning. In Massachusetts, the Department of Mental Health promotes recovery and resilience through community integration, health and wellness, and access to services and supports.

From the discussion at this meeting, it is clear that most of our training programs provide us with unique opportunities to work in the Public Sector.

The Accreditation Council of Graduate Medical Education (ACGME) requires training in community psychiatry to be part of adult psychiatric residency. Since the specific content of community psychiatry training is not always clearly stated, Dr. Derri Shetsel along with other physicians described an approach to training in community psychiatry. In their column in the Harvard Review of Psychiatry, they noted that becoming a community psychiatrist requires the ability to work in interdisciplinary teams and collaboratively with primary care providers and non-medical colleagues. They also suggest that there is a need to train residents to work simultaneously at the personal and systems levels.

The night of the meeting, as I heard my colleagues describe their experiences in Public Sector Psychiatry, I remembered the romantic and hopeful views most of us had when we chose to go into medicine. Most of us reasoned to have been drawn to medicine “to help sick people and make a difference”. However, during my last few years of medical school and the beginning of residency, I noticed how this motivation seemed to fade with every USMLE test, every difficult call, and long hours of work. The humanistic qualities of medicine can get compromised with the constant demands of our work. Nevertheless, humanistic qualities are essential to work in the Public Sector. In this setting we encounter the sickest individuals, who have the least amount of resources, and need much more than just a pill. They need psychological help, social support, hope, and a connection with the world. As we have seen in our rotations, working in the community requires long work hours, and going the extra mile. Above all, it requires particular emotional strength from the clinician. For these same reasons, I believe it is that much more rewarding.

Psychiatry training has followed a more biologically oriented approach, with less emphasis on psychosocial interventions. Sometimes I have wondered if they are mutually exclusive. However, I was pleasantly surprised when I heard so many residents talk about their interest in continuing to work in the public sector, and serve the population that needs it the most. Listening to my colleagues talk so wholeheartedly about their interactions with patients in these settings, gave me hope that humanism in psychiatry is not lost.

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• The Behavioral Health Task Force report was finalized and sent to the legislature. MPS will continue to work to address areas we support and those that we do not, partnering with like-minded organizations to achieve the best possible outcome for psychiatry and our patients.

• One area in the task force report that MPS explicitly opposed is expansion of scope of practice. The specific example within the report was to allow unsupervised advanced practice nurses to treat patients with behavioral health disorders. This scope of practice expansion for advanced practice nurses in mental health is now proposed in a legislative bill. MPS leadership believes that patient safety and quality care are the primary element in any healthcare system change. We posit that the proposed scope of practice expansion is based on the false assumption that unsupervised practice for advanced practice nurses will increase access to care. While we acknowledge that advance practice nurses working closely with and supervised by physicians in many areas of medical practice offer much for patient care, we believe that unsupervised practice will adversely affect patient safety and quality of care without changing the basic economic infrastructure that created problems in access to care. This is one area of the proposed integration of behavioral health and primary care integration that we discussed this summer with our medical colleague leaders at the Massachusetts Medical Society (MMS). Increasing the numbers of MPS members in MMS will strengthen this alliance as we work on issues of shared concern in healthcare reform. [For information, see http://www.massmed.org/].

• Our Managed Care group continues to meet with both private insurers and MassHealth to effect positive change that we hope will compel insurers to meet the mandate of parity in the use of the CMS CPT. Changes in these codes were made to bring psychiatric reimbursement into alignment with other medical specialties and reflect the complexity of care we provide. [see Managed Care Committee Column in this newsletter]

• On a national level, a proposal for a permanent Medicare correction to the flawed 1997 Sustainable Growth Rate (SGR) provision that created the formula intended to rein in healthcare costs is recently unanimously out of the House Ways and Means Committee. This perennial issue has led to five temporary fixes to avoid drastic cuts in payment for physician services that would, if implemented, lead to disruption in care and limited access to care for the disabled and retired citizens. This legislation is closely followed by the APA and other national groups with input from District Branches through our MPS APA Representatives. [For more information see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2013p.pdf].

• The release of DSM 5 has left many of us dealing with a hybrid use of DSM 5 and DSM IV-TR, as different groups and organizations make the transition to full use of new diagnostic criteria. This is particularly true for our members-in-training and academic psychiatrists with the use of DSM IV-TR in ABPN examinations through 2016 and the shift to DSM 5 for the 2017 examinations. Others such as the Veterans Healthcare will begin the use of DSM 5 in October 2013 with a great deal of variation in organizational implementation. The variations in use will leave training programs with a matrix of old and new diagnostic criteria for several years. MPS remains ready to assist its members in mastering the material to make the changes become seamless [see CME course on MPS webpage].

As innovations in healthcare take place in Massachusetts, MPS must remain vigilant to ensure that patient safety and quality assurance continue as a cornerstone of our professional beliefs. MPS has and will continue to partner with physician professional organizations to effectively address issues as healthcare is reorganized. As in all change, time will be the test. Change is a process and not an event. MPS is positioned to challenge what needs to be challenged, support what needs to be supported, and provide expert knowledge to legislatures and administrators when it is needed in this process. As we sail these uncharted waters, we are among a fleet of physicians whose organizations understand that patient care demands both quality and access with physicians at the helm in care delivery. Our patients deserve no less.

Respectfully,

Janet E. Osterman, MD
President
Having done most of my clinical clerkships in New York City, I came to Boston for residency expecting a similar experience in another metropolitan city. The culture of the Psychiatric Urgent Care units I observed in NYC consisted of a triage system in which some patients would be discharged and some, with enough evidence, (which is likely suicidal ideation, homicidal ideation or severe psychosis) would be admitted. Some patients would be in that area between admission and discharge. For those in-between situations, there was a statewide program available in some, but not all, hospitals called the Comprehensive Psychiatric Emergency Program (CPEP). CPEP is essentially an observation and holding area in the emergency room where patients needing further observation would be kept for up to 72 hours prior to discharge. Not surprisingly, it is often used as a quick and dirty detox “program”. This concept is common in EDs nationwide without a title or a special room. They are not “comprehensive” in other EDs around the nation, as these patients sober up and leave in much less than 72 hours, many times without a psychiatric assessment and are likely to return soon.

Thus, one could imagine the surprised look on my face when, during one of my first few calls as a resident, I heard my senior’s sign out to the admitting floor: “This is mainly a detox and humanitarian task. The patient is homeless and suffering from long term alcohol dependence.” Humanitarian admission due to alcohol dependence and homelessness, I wondered? What was the clinical judgment used here? This is not a hotel, it is a hospital, I thought to myself.

During rounds the next morning, I heard the attending speak of our “mission to end homelessness.” As a new physician, I was still in the inquiry mode, thinking like an engineer, wondering what is the problem we are treating and why is our homeless and alcohol-dependent patient still here? As much as I liked that mode, however, the attending’s words resonated with another part of me, which I had, perhaps, ignored for a few years. This situation took me back to my public health training days and my idealistic dreams as a graduate student. Dr. Cousineau, my mentor at the University of Southern California Keck’s School of Public Health, who works on impact of health policy on the homeless helped instill the same vision in me: to eliminate homelessness.

While skeptical about the practice of medicine I had just witnessed, I thought about other idealistic “what ifs”: What if I could securely access my patient’s records all day, every day, and anywhere in the world so that I could make myself available to oversee their care regardless of where I was in the world? What if I could assure my patients’ continuity of care in any state as long as they walk into a hospital and request for help? Their previous records would be available, my recommendations, their active medication list, everything!

What if I could access the notes from multi-disciplinary medical professionals to know what they were doing for my patient as well? After all, knowing what his/her primary care and neurologist are doing could really help me out when I am deciding on my treatment plan and options. What if I could share my notes with other providers by just looking them up and “tagging” them on my notes much the same way you tag a person on a Facebook photo, and maybe even get them to acknowledge receipt of my note by an electronic signature?

What if I had a system that would automatically send me alerts (again like Facebook) when people wanted me to read a note or when things were wrong? For instance, if I ordered labs that came back with abnormal values or if the pharmacist wanted me to fix a mistake on the prescription I had written. Similarly, what if there was a system that would alert me of any med-med interactions before I signed a script?

What if I could click a button and see all the medications my patient had tried in the past? Instead of suggestions or referral with a business card, what if I could place outpatient consults that would generate automatic appointments for my patients and those specialists could also read my patient’s history?

What if…what if? And what if I told you that while the elimination of homelessness has not yet occurred the rest of the “what ifs” are the reality of today’s VA healthcare system. Dream no more! This system has
existed long before Facebook ever did and mainly due to the nationally available, VPN connected, and tightly monitored and secured electronic medical record system.

This system is so natural to use and so obviously needed that, much like a beating heart, I used it for months without thinking about the miracle it actually was. During these months I further learned to think less like an engineer and more like a psychiatrist: one who considers the “bio,” the “psycho,” and the “social” aspects of the patients. I learned that in order to carry out care in a holistic manner, continuity of care, history, collateral information, and communication between providers are essential elements. In conclusion, I witnessed that the VA’s success in delivering mental healthcare to patients in such fashion is owed to the organization’s two major strengths:

One is the VA’s culture of provision of care: All honorably discharged veterans receive quality care regardless of disease, severity, and socio economic status (notice insurance companies have been minimized in this system—a separate debate not discussed here.) No matter where one lies on Obama’s Affordable Care Act, providing an “all-inclusive quality of care to all US citizens and residents” is nothing more than an idealistic dream by most providers, yet provision of care to all honorably discharged veterans is a reality for VA Clinicians. All the while, the VA healthcare system rates quite high on objective quality measures as well.

For example, in the case of our original dual-diagnosis patient, VA clinicians know that a 24 to 72 hour detox at the “Comprehensive” Psychiatric Emergency Program, while a great band aid, will do nothing to treat the underlying problem of substance dependence and/or the comorbid mental illness. The “quick and dirty” is replaced by a system that enables us to educate you and provide options for mental healthcare, long-term abstinence programs, and housing. There will be those who will abuse the system and sign out AMA. However, our job as doctors is to treat the core of the disease and not just the symptoms. Additionally, the patient who signed out AMA after a shower could transition from pre-contemplation to contemplation due to the brief motivational interviewing between admission and his shower. Every interaction is a chance for intervention.

The VA system of mental health is one which caters to patients’ needs, even if that need is to be “taken in and taken care of” at any stage. This system has invested heavily in preventive, rehabilitative and population-based care. It is a public health model that deserves further discussions for adaptation by other healthcare institutions. “You are not alone, we are here to help” is what I learned to say to my patients after the end of my first year as a resident in the VA system, and I meant it.

The second strength of the VA system is that it has the technology and tools needed to deliver high quality of care to all US veterans. The VA electronic medical record system is the largest, most inclusive and secure system used in this country. Patients move across the country and their care is transferred instantly. If patients visit other states, their health records are available at a moment’s notice. New developments also include creating phone apps for veterans and, through telehealth, bringing mental health into the homes of patients who have trouble coming to clinic. Use of such technology should be standard of practice in the 21st century, especially within the most technologically advanced country in the world.

The VA’s mental health system operates in a way that all healthcare systems should: It focuses on the long-term, as opposed to looking only at short-term solutions. It looks at the bigger picture and addresses the core of the problems. The VA mental health care system expects and delivers higher quality of care and comprehensiveness that is a standard of care nationwide.

The above certainly will leave many with the reflexive question of “who will pay for this?” The hospitals, healthcare providers, government, and taxpayers are the ones who will pick up the tab left by those undertreated. The citizens are the ones who fund public programs, such as Medicaid, which will ultimately pay for the circular cost of “band aid care.” The extra work done to help these revolving-door emergency-room patients falls on the shoulder of providers as well. Therefore in one-way or another, we are all paying for our healthcare system. What we should aim for is efficiency and cost-effectiveness. These goals are achieved through coupling technology with comprehensive care (including preventive care- not fully discussed here). The VA system for mental health care successfully manages and caters to some of the most complex and seriously mentally ill patients using this motto. Additionally, it addresses cost avoidance by dealing upfront with broken lives that would otherwise end up in ERs or ICUs over decades.

While many aspire to look outside countries such as Canada or the United Kingdom, to piece together the good in order to reform our healthcare system, one should not forget to look at the VA system within and especially the mental health division of this system. The model we should further study and learn from when we think of “reform for provision and continuity of care” is as American as the Federal Government’s VA system and has been a very large “pilot” here at home. It is advanced culturally and technologically, has passed the test of time, and it works by making life better for providers through making it better for patients.

Edwin Raffi, MD, MPH is a resident physician at the Harvard South Shore Psychiatry training program and a Member In Training co-leader for the Massachusetts Psychiatric Society VA Committee.

MPS ORGANIZATIONAL PSYCHIATRY INTEREST GROUP

The MPS Organizational Psychiatry Interest Group will host “Speaking to leaders: management coaching, team building, and facilitating organizational change” on Wednesday, September 18, at MPS, 40 Washington Street, Suite 201, Wellesley Hills, MA 02481.

This activity will offer participants an opportunity to know more about Organizational psychiatry and its importance in health care, law, education and business.

Kenneth M. Settel, M.D, is our expert for this event. The program will provide an interactive discussion and address participant questions. We will start at 7:00pm, and encourage you to arrive at 6:30pm, that will give you a chance to mingle with other participants. A program brochure will be available soon.
Managed Care Committee
Gregory G. Harris, MD, MPH, Chair

Important announcement about impending Medicare Part B Vendor change for “Jurisdiction K”:
If you are a Medicare Part B provider for outpatient services, you should already have received notification of an impending vendor change for billing and operations. If not, you need to become educated about this transition and prepare to make the change before the cutoff date of October 25th, 2013. Medicare Part B divides the country into “jurisdictions” for the purposes of bidding out administrative contracts to manage the Medicare benefit. Massachusetts is in “Jurisdiction K” and will have a new contractor, National Government Services (NGS) replacing the current vendor, National Health Information Center (NHIC).

Make sure to visit the transition page: http://tinyurl.com/opjmkt or the NGS web site for registration details at http://www.NGSMedicare.com and select the Part B Medicare contract. NGS will be providing multiple training webinars to help with the transition and make sure to subscribe to receive announcements from NGS if you have not already done so. You can find information about NHIC at http://www.medicarenhic.com.

Update on recent GIC changes in mental health coverage:
As previously reported, the Group Insurance Commission (GIC), which is responsible for health insurance coverage for all state employees as well as many municipal employees and retirees, altered coverage for many people starting on July 1, 2013. As of that date, GIC employees with Tufts, Fallon and Unicare have their behavioral health coverage through Beacon Health Strategies (BHS). GIC employees with Harvard Pilgrim Health Care (HPHC) retained behavioral health coverage through United Behavioral Health (UBH). GIC employees with new coverage throughout BHS have an out of network benefit for the first three months, but starting on October 1, 2013, will be required to see in-network providers. We remain uncertain how long patients with HPHC/UBH plans are being “grandfathered” and will retain coverage with UBH, but it is for the foreseeable future. We continue to recommend that MPS members vigorously negotiate with BHS if they are interested in being in the network.

MPS reached out (in conjunction with NAMI and Health Law Advocates (HLA)) to the GIC about our concerns with the transition and had a first meeting with members of the Commission and Beacon. We plan to meet again in the fall and hopefully regularly. We continue to encourage MPS members to communicate parity and network concerns with their patients and encourage them to voice these concerns directly with their employers, union, the GIC and BHS.

Audits and Case Reviews:
UBH continues to review and audit cases, while BCBSMA and Tufts are instead collecting data over the first 6-12 months of 2013 prior to determining an audit process. (Remember that every managed care contract allows the MCO the right to audit cases and to request records for auditing purposes. We are concerned that these auditing procedures be reasonable.

It still appears that UBH are largely looking at two categories of cases:
1. “Random” audits of cases from many providers: they appear to be looking at higher-level E&M codes (99214&5) with or without psychotherapy add-ons. So far this process appears reasonable and UBH are paying for audited visits.
2. “Outlier” clinical reviews with particular providers, requesting to review “practice patterns”. Our members continue to find these reviews intimidating, insulting and time consuming. They appear to generally be targeted at relatively low-volume providers with a high proportion of patients undergoing long-term weekly (or greater) psychotherapy. While we understand UBH’s need to audit outlier practitioners, we continue to feel that this is an unreasonable process and are working with APA to attempt to address the problem. Please continue to report these cases to MPS and to APA when they occur.

NY State Psychiatric Association (another APA district branch) has a class action suit that raises some of these problems and APA is actively working on this case. There’s no specific news to report, but fingers crossed!

BCBSMA Copayment Issues and EFT Policy:
1. BCBSMA have reportedly corrected payment errors to Psychiatrist caused by their conflicting policy of one (higher) copayment for “specialists” and another (lower) copayment for “behavioral health”. They have committed to the lower copayment for Psychiatrist, no matter whether E&M or psychotherapy (or both) services are provided. You should have received correction payments. If you are still seeing problems please let us know through the links below.

2. BCBSMA will be mandating that all providers accept electronic EFT payments starting in November 2013; please look at their website and FPI announcements for details. This will not be optional except in severe “hardship” cases, but they have support in place to assist with the transition to their new vendor, Payspan, what will be handling EFT payments and EOBs. Masshealth already uses Payspan, and other MCOs are likely to go this route as well. BCBSMA have assured us that payments will be handed with EFT, but that their policy for overpayments has not changed and will be handled manually. Also, this policy is for payment and NOT for claims submission, which may still be performed with paper claims.

Mental Health Parity and CPT Coding Changes for 2013:
We have testified regarding Parity and the new CPT codes at the Massachusetts Office of the Attorney General, the Massachusetts Division of Insurance and the Massachusetts Legislature. We want to again thank all who continue to report problems regarding the new 2013 CPT coding scheme. We are actively using your case reports in our advocacy and ask that you continue to report difficulties to the MPS e-mail address: managedcarecommittee@psychiatry-mps.org

Please continue to report concerns both the MPS and to APA through:
1. an online form: https://www.surveymonkey.com/s/cptparityviolations
   or
2. via a dedicated e-mail address: cptparityviolations@psych.org
   general information can be found at: http://www.psychiatry.org/cptparityviolations

APA has a list of parity actions by state at: http://www.psychiatry.org/practice/managing-a-practice/cpt-parity-abuses/apacpt-parity-actions

Denials of Service Concerns from APA OHCSC (please reference June’s column): can be reported to APAMemberparityviolations@psych.org

DSM-5:
Please see Dr. Carlene MacMillan’s excellent column to keep abreast of changes in the new DSM-5. We will be working together on these issues, but some areas of interest related to practice are discussed on the www.DSM5.org website.

1. CODING CORRECTIONS:


3. BCBSMA have committed to using ICD-9 codes and DSM-IV codes through the end of the calendar year; we encourage MPS members to become familiar with ICD-9 codes (a subset are the new DSM-5 codes), since these codes encompass areas of general medicine as well as psychosocial concerns, etc. that will be of use in coding and documenting the 2013 CPT codes.

Remember, all are welcome at the Managed Care Committee Meetings, which occur on the third Tuesday of the month (from 7:00 pm—9:00pm; dinner served!) at the MPS offices in Wellesley. Check the MPS website for details or contact me at gregorygharris@sprynet.com

Gregory G. Harris, MD, MPH, Chair

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MPS Bulletin—September 2013
Imagine the following hypothetical case presents for an intake: You first meet Oscar, a 9 year old boy, in your waiting room as he is refusing to enter your office. When his mother told him to put his Nintendo DS away to go into the appointment, he began screaming, promptly began shredding the waiting room magazines, was spitting at his mother and flipped over a large table. His mom appears tired and frustrated but not particularly phased by this outburst. She explains these episodes have been happening at least 3 or 4 times every week. Two days ago, he threw his older sister's soccer trophy at her, narrowly missing her head but breaking her bedroom window. He was angry that she told him she would take him to the mall but changed her mind when they got into yet another protracted argument over changing the TV channel. She refers to her brother as “Oscar the Grouch” because he is always so testy. He is struggling in school socially and academically and got kicked out of summer camp. He frequently has a tantrum regarding staying up past his bedtime but once asleep, gets around 7 hours of sleep and hates to wake up in the morning. There is a strong family history of both ADHD and depression. His parents got divorced last year and have been under increased financial stress as a result.

You appreciate immediately that Oscar is quite impaired by his symptoms but determining a suitable diagnosis and treatment plan may be less clear. If you have started incorporating DSM-5 into your practice, a diagnosis of Disruptive Mood Dysregulation Disorder (DMDD) may have made its way onto your differential. That is, of course, if you believe it is likely a valid diagnostic entity. The extensive controversy surrounding the inclusion of this diagnosis in the main body of the DSM-5 spans from concerns in the lay press that it pathologizes the tantrums that are part and parcel of being a kid to concerns from clinicians and researchers that there is not enough evidence at this time to confidently assert that it is an actual disorder. One of the most vocal critics of the DSM-5, Allen Frances who is the psychiatrist who chaired the DSM-IV Task Force, has even granted DMDD the number one slot on his list of the “Ten Worst Changes” in the DSM-5 that clinicians should ignore. Rather than bury our heads in the sand, however, I think that taking a closer look at the nuts and bolts of DMDD is the first step in determining what impact it might have, whether or not it adds anything useful for our patients, and what its fate should be in future iterations of the DSM.

The main impetus for conceptualizing the DMDD diagnosis has been concern about a marked 40-fold increase in the number of children diagnosed with Pediatric Bipolar Disorder from 1994 to 2003. A natural consequence has been that a larger number of children are now taking atypical antipsychotics and mood-stabilizers with potentially serious long-term side effects. These trends stem from the guidance of a number of prominent researchers in the field of child psychiatry who have proposed that extreme and frequent irritability can be considered the developmental equivalent of adult mania. The cardinal manic symptoms of euphoria, elation and grandiosity need not make an appearance. However, some studies have suggested that these chronically irritable children that have episodic affective storms lasting hours, not weeks, do not necessarily grow up to be bipolar adults. The DSM-5 Childhood and Adolescent Disorders and Mood Disorders Work Groups proposed that DMDD may be a better “diagnostic home” for some of these cases as it only applies to children ages 6 to 18 and does not imply the child has a lifelong mood disorder.

The core criteria for DMDD include the occurrence at least 3 times/week for at least 12 months of severe recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation and the mood between outbursts is characterized as persistently irritable or angry for most of the day. There can be no more than 3 consecutive months within the year where symptoms abate and the symptoms must be present in at least two settings. If children also exhibit symptoms suggestive of Oppositional Defiant Disorder (ODD), DMDD trumps the ODD diagnosis. In an obvious effort to distance it from bipolar disorder, DMDD is located in the Depressive Disorders chapter rather than the Bipolar and Related Disorders chapter. For ICD-9 coding purposes, though, it is coded as 296.99: Other Specified Episodic Mood Disorder.

There have been some preliminary studies attempting to address prevalence and comorbidity patterns of DMDD and so far two main themes have emerged. The first is that actually meeting the criteria is quite hard to do and so the prevalence is likely very low (~0.8-3.3%), providing a counterpoint to the claim that “normal tantrums” are being pathologized (Copeland et al., 2013). The second theme is that around 80% or more of these children also have a plethora of symptoms consistent with ADHD and externalizing behavior disorders (ODD or conduct disorder). Depression is very common in this population as well (Axelson et al., 2012). This has led some critics of the disorder to argue that there is not a need for this new diagnosis because diagnosing a child with “virulent ADHD/ODD” adequately describes the constellation of symptoms. Furthermore, patients with ADHD and comorbid ODD often respond well to a combination of stimulants and behavioral interventions including significant parental guidance. When a new diagnostic category is created, critics argue, it becomes an obvious target for the pharmaceutical industry and the number of children being prescribed antipsychotics and mood-stabilizers could conceivably increase, worsening the very problem DMDD was supposed to help address.

An essential and humbling perspective to maintain is that after an initial intake, a definitive diagnosis is often not possible and over time the differential narrows. Given that there is clinical equipoise regarding whether or not DMDD is a useful and valid concept, keeping it in mind for certain cases may be prudent as the field gathers more data on it. Because no evidence-based treatment recommendations exist at this time for DMDD, deciding how to proceed if DMDD is a diagnosis being entertained is challenging. A recent article by two psychologists has suggested a number of approaches to tease apart the differential

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Dr. Falls served as resident co-chair of the MPS Forensic Psychiatry Interest Group from 2011-2013. He graduated from Harvard South Shore residency in June 2013. He recently applied to forensic psychiatry fellowship programs and is currently a forensic fellow at the University of California Davis.

This article, after a brief introduction to psychiatry fellowships, discusses how psychiatry residents can learn about fellowship programs and distinguish themselves as applicants. It also reviews the particulars of applying to and interviewing at psychiatry fellowships.

Fellowships are training experiences that residents can participate in after their general psychiatry residency to further their knowledge in a psychiatric subspecialty. There are currently five types of ACGME-accredited fellowships that fall under the purview of psychiatry: Child and Adolescent Psychiatry (CAP), Psychosomatic Medicine, Addiction Psychiatry, Geriatric Psychiatry, and Forensic Psychiatry. Most of these fellowships last for one year, with the exception of CAP fellowships, which are two years.

In addition to these, psychiatry residents can elect to enter ACGME-accredited, one-year multidisciplinary fellowships in Clinical Neuropsychology, Hospice and Palliative Medicine, Pain Medicine or Sleep Medicine. A number of non-ACGME-accredited fellowships also exist, ranging in length. Such programs include (but are not limited to) Neuropsychiatry, Emergency Psychiatry, Public/Community Psychiatry, and a host of research fellowships.

A great resource for learning more about accredited fellowships is the Fellowship and Residency Electronic Interactive Database (FREIDA) Residency/Fellowship Training Search at www.ama-assn.org/go/freida. More detailed information about the geriatric and forensic psychiatry subspecialties — individual program information and links to program websites — can be found at http://www.aaplonline.org, and www.aapl.org/fellow, respectively.

If, after learning more about a certain psychiatric subspecialty, you determine you would like to apply to fellowship programs, begin considering how you will distinguish yourself as an applicant. It may seem obvious, but a highly important attribute of an applicant to a fellowship program is his or her level of interest in the subspecialty. There are other ways that candidates can enhance their candidacy for a program but
demonstrating a genuine desire to learn about and practice in the subspecialty seems to be a key factor in being selected. Program directors will see your excitement in your application through any activities you have done pertaining to the subspecialty. You can use PG4 year elective time offered by most psychiatry residencies to get experience in your selected field. If your program does not have elective rotations in the subspecialty you are considering, most programs allow residents to petition for an away elective at another institution. Training directors will also appraise your interest by looking at extracurricular activities involving the subspecialty, including publications in the field and membership or leadership in related organizations. Finally, you can demonstrate interest in your personal statement and during your interview (both discussed below).

At some point (no later than fall of the PG4 year or, for “fast-track” CAP fellows, the PG3 year) you should start learning about the various programs in the subspecialty you have selected. That way, you can narrow the field to a handful of programs that best suit you and subsequently apply to them. To get an idea of a program’s strengths and areas of focus, you can: 1) contact the program director or faculty (using the contact information on each program’s website) to directly inquire about their focus and to learn about rotation sites and experiences; 2) electronically peruse the faculty’s research and teaching activities on program websites; and 3) read faculty’s articles, book chapters and even textbooks.

Fellowships in Psychosomatic Medicine, CAP, Pain Medicine and Sleep Medicine all use the National Resident Matching Program, the same program used for general residency programs. The rest of the subspecialty fellowships do not use a match system. Instead, they have a “rolling admissions” process, meaning program directors offer positions in real-time as they find applicants who seem compatible with the goals of their program. This system fosters an eagerness to match quickly amongst programs and applicants alike. Consequently, it is best to have applications completed and submitted early.

Application due dates can be found on the aforementioned FREIDA website for fellowships using the match system. For subspecialties that do not participate in the match, every program has its own deadline, so it is important to check with each. Most program applications request basic demographic data, medical school/residency information, a personal statement, and reference letters. Forensic fellowships usually request at least one forensic writing sample. Once again, requirements vary between fellowships, so be sure to check with individual programs.

Generally speaking, the same rules apply for fellowship interviews as to all professional interviews. As with medical school and residency interviews, you want to be punctual (if an emergency arises, call!), and to convey yourself professionally with your attire, speech, and behavior.

The interview day is a great time to get to know the program. Just as the faculty are discovering whether your interests and abilities match the educational focus and opportunities of the program, you should be ascertaining whether the fellowship’s training environment will help you fulfill your goals. Try to get a good understanding of each of the rotations and clinical experiences, as well as the didactic schedule and content. Taking notes about the pros and cons is often helpful to jog your memory later, especially if you are applying several programs.

When you interview, you should really try to gauge the faculty’s level of commitment to personally investing in their fellows’ education. This is especially important in some subspecialties, because programs are usually much smaller than general residencies and the dedication of just a few individuals (one training director, a handful of full-time faculty, and usually an associate director) help create an environment for the program to meet your objectives.

The interview day itself represents your final—and most enduring in the minds of interviewers—chance to demonstrate your enthusiasm for the particular field. You can do this by asking a lot of well-researched questions about the fellowship, and discussing the aforementioned extracurricular activities that distinguish you as a solid prospective subspecialist. Most interviews are fairly relaxed, so don’t forget to enjoy this once-in-a-lifetime process!
Riverside Community Care provides more than 40,000 adults, children and adolescents each year with a broad range of healthcare and human services. We are an award-winning, non-profit organization offering programs in mental healthcare, developmental and cognitive disabilities, addiction treatment, and early childhood services. We are here to make a difference in the lives of individuals, families, and communities by delivering compassionate, locally-based, integrated care. Currently we have many job opportunities across Massachusetts and 2 listed below for Norwood, Ma. Please apply and visit our careers page at www.riversidecc.org/careers

**Adult Psychiatrist – Part time**

Great part-time opportunity for an Adult Psychiatrist to work in a warm and collegial environment as part of a specialized multi-disciplinary treatment team which provides behavioral health care for individuals with intellectual and developmental disabilities. A key service provider in the area, our clinic is located near the center of Norwood and is part of one of the largest and most respected CMHCs in Massachusetts. Primary responsibilities include prescribing and medication management for DDS clients 18 and older, participation in team meetings, consultation to clinical staff and managers, and collaboration with other behavioral health and human service providers in the area.

Must be a licensed physician in the state of Massachusetts with a current DEA certificate and Board Certified or Board Eligible in psychiatry.

Previous experience in a community mental health setting as a prescribing psychiatrist preferred.

**Psychiatrist/Prescribing Nurse – Part time**

Part time – 24 hours per week - benefits eligible position available in a well established and highly respected community mental health center for a prescribing nurse clinical specialist. Responsibilities include providing psychiatric evaluation and medication management. Regular supervision provided by the Medical Director.

Position requires a license to prescribe.

Previous prescribing experience and four years experience as a psychiatric clinical nurse specialist.

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**The Department of Psychiatry at the Beth Israel Deaconess Medical Center** is recruiting psychiatrists for its Psychiatric Consultation Service and for its Cognitive Neurology unit.

Beth Israel Deaconess Medical Center in Boston, MA is a 500+ bed tertiary care teaching hospital of Harvard Medical School. The Department of Psychiatry maintains a diverse 25 bed inpatient unit, a robust Emergency Department and Consultation-Liaison Service, as well as an active outpatient practice. The Department of Psychiatry is a major teaching site for Harvard Medical School and the Harvard Longwood Psychiatry Residency Training Program; all positions will include opportunities for teaching medical students and residents. Underrepresented minorities are encouraged to apply. Interest and experience in research is desirable. Harvard Medical School appointment at an appropriate rank is available.

1. **DIRECTOR OF THE PSYCHIATRIC CONSULTATION SERVICE.** This is a key leadership position within the Department of Psychiatry and includes oversight of clinical care and teaching on a busy service which sees 2300 Emergency Department and 1000 Inpatient Medical-Surgical consultations annually. Applicants should have certification in Psychosomatic Medicine; interest and experience in research is desirable.

2. **STAFF PSYCHIATRIST ON THE PSYCHIATRIC CONSULTATION SERVICE.** This is a half-time or greater position that includes clinical care, teaching, and supervision on the service. Certification (or eligibility) in Psychosomatic Medicine and interest and experience in research is desirable.

3. **STAFF PSYCHIATRIST IN THE COGNITIVE NEUROLOGY UNIT.** This is a three-quarter to full time position in a multidisciplinary clinical unit that serves a variety of neurological patients, including patients with degenerative disorders, developmental disorders, epilepsy, attention deficit disorder, and traumatic brain injury. The psychiatrist will work primarily in the outpatient setting but is also expected to be available for some inpatient consultations. Participation in educational and research programs in the CNU and Division of Epilepsy is expected.

Please send a letter of interest, CV, and contact information for three references to William Greenberg, MD, Chief of Psychiatry, by email: wgreenbe@bidmc.harvard.edu.
BUSINESS SERVICES

LEGAL ADVICE FOR PSYCHIATRISTS
Milton L. Kerstein, Esq.
Andrew L. Hyams, Esq.

Mr. Hyams, former General Counsel to the Bd. of Reg. in Medicine, and Mr. Kerstein provide legal services to psychiatrists and other health professionals in the following areas:

- Licensing Board Complaints and Applications
- Medicare/Medicaid Audits
- Patient Confidentiality
- Provider and Employer Contracts
- Civil/Criminal Litigation

As a service to Bulletin readers, we offer one free 15-minute consultation to discuss any general legal concerns.

Kerstein, Coren & Lichtenstein, LLP
60 Walnut Street, Wellesley, MA 02481
www.KCL-law.com
(617) 969-7139

Harvard Square (Cambridge): Furnished psychotherapy office sublet in renovated Victorian house. Shared waiting area/bathrooms/kitchen. Join wonderful group of multidisciplinary clinicians. Rent: $176/month per 4-hour/week block. Half-time morning (Mon-Fri, 7am-11am) sublet also available in alternate office. Contact harvardsquarealliance@gmail.com / 617-230-3002

Brookline: Sunny and spacious office available in Brookline, located across the St Mary’s T on the green line, on the same block of the newly open Whole Foods Market. For information call Margarita Alvarez at 617-277-2424 or Claudio Demb at 617-519-0377 or email claudi-odemb@gmail.com

Cambridge-Sunny corner office in 2-office suite in professional building on Concord Ave. First floor suite includes waiting room, bathroom, kitchenette, free parking, easy bus access to Harvard Sq. $750/mo + utilities for full time. Hourly sublet may be possible. Call Carlene:617-419-0775 or email cmacmillan@partners.org

THE DEADLINE FOR THE OCTOBER 2013 MPS NEWSLETTER IS SEPTEMBER 20, 2013.
FOR ADDITIONAL ADVERTISING INFORMATION, PLEASE CONTACT THE MPS OFFICE AT: (781) 237-8100 OR MPS@PSYCHIATRY-MPS.ORG
STAFF PSYCHIATRIST POSTIONS.

Full and part-time positions are available for ADULT PSYCHIATRISTS in our outpatient clinics in Framingham, Marlboro and satellites. Advocates Inc is a full-service, non-profit system serving individuals with psychiatric and developmental disabilities and other challenges in a strength-based, person-centered and multidisciplinary setting. Excellent physicians are honored, and we offer a warm, friendly practice environment. Compensation is competitive and benefits are available for 20 hours +.

Contact in confidence Chris Gordon, MD, Medical Director at 508.628.6652 or at chrisgordon@advocatesinc.org.

Medical Director

North Charles is looking for a Medical Director for the North Charles Opioid (methadone) Treatment Program, affiliated with the Department of Psychiatry, Cambridge Health Alliance and Harvard Medical School. Responsibilities include medical and clinical oversight of treatment services including admissions, treatment planning, annual treatment reviews, and consultations for medical and psychiatric emergencies, working with multidisciplinary treatment team, and participating in training of medical and psychiatric residents and addiction psychiatry fellows. The position requires 8-10 on-site hours with beeper back-up.

Women’s Wellness Center

North Andover, MA

Seeking psychotherapists, nurse practitioners, psychiatrist and nutritionist to share office furnished office space. Ideal co-tenants are clinicians specializing in the treatment of women or children and interested in collaborating to provide comprehensive behavioral health care to women and children.

Offices are newly renovated and furnished and include kitchenette and spacious waiting room. Plenty of parking, very well maintained building with newly renovated restrooms.

Please call Tarin McCabe at 978-683-4266.

Tewksbury Hospital

Unique full time opportunity for psychiatrist comfortable with treating medically complex behaviorally challenged DMH patients on the Medically Enhanced Unit (MEU) of Tewksbury Hospital. This unit draws medically compromised psychiatric patients from throughout Massachusetts, bringing together in one place enhanced medical coverage (one full time internist and a half time medical nurse practitioner), with enriched and specialized PT/OT, psychology, and nursing resources to promote recovery and discharge to the community. Specialty consultation available (endocrinology, pulmonology, respiratory therapy, neurology, etc) on site. Opportunity for clinical leadership.

Send CV to Linda.Bishop@dmh.state.ma.us or contact Anthony Vagnucci, MD, chief of psychiatry, at 978-851-7321, ext. 2863.

Cambridge Psychiatric Services

PSYCHIATRISTS:

Interested in flexible hours, competitive pay rates, and a schedule that fits your needs?

Qualified psychiatrists needed to provide overnight, weekend, and holiday moonlighting coverage at area hospitals, clinics, and other psychiatric facilities.

For more information please call Jessica D’Angio at 617-864-7452 or at jdangio@northcharles.org

More than just medical professional liability insurance...

How Much is Your Reputation Worth?

We have the comprehensive coverage you need to protect your reputation and practice setting.

Should you face an investigation from a state licensing board or governmental agency related to billing, participation on an insurance panel, a professional society inquiry or any other administrative defense issue, our policy provides $50,000 administrative defense coverage at no additional charge.

There is no deductible and we assign you an attorney so you don’t pay out-of-pocket expenses.

Contact us today for your customized quote.

- More than 20,000 psychiatric claims handled
- Over 40,000 issues responded to by the Risk Management Consultation Service (RMCS) since inception in 1997
- Accredited by the ACCME
- Administrative and governmental billing defense coverage
- Coverage for forensic and telemedicine psychiatric services
- ECT/EST included at no additional charge
- Premium discounts - and much more!
### CAMBRIDGE: Adult Psychiatry

**Position available at Cambridge Health Alliance, Harvard Medical School.** We are seeking a full-time psychiatrist to work in both our adult outpatient psychiatry and psychiatry transition services. Clinical care is provided through a multidisciplinary team approach with psychiatrist leadership. Responsibilities include direct clinical care as well as supervision of trainees and other mental health providers. Opportunities exist to develop new services and work in flexible settings. Some hours available in our outpatient addictions service as a prescriber in a structured Suboxone clinic. 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 many opportunities for teaching, as well as innovative programs for medical students. Academic appointment is anticipated, as determined by the criteria of Harvard Medical School.

**Qualifications:** BE/BC, demonstrated commitment to public sector populations, strong clinical skills, team oriented, problem solver. Interest and/or experience with dual diagnosis patients a plus. Cambridge Health Alliance is an Equal Employment Opportunity employer, and women and minority candidates are strongly encouraged to apply. CV & letter to Susan Lewis, Department of Psychiatry, 1493 Cambridge Street, Cambridge, MA; Fax: 617-665-1204. **Email preferred:** SLewis@challiance.org.

### CAMBRIDGE: Outpatient Consultation-Liaison Psychiatry Position

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

**Qualifications:** BC, strong clinical skills, commitment to public sector populations, team oriented, problem solver, interested in working closely with primary care and medical specialists. Fellowship training in Psychosomatic Medicine, as well as bilingual and/or bicultural abilities, is desirable. Interest and experience with substance use disorders preferred. We offer competitive compensation and excellent benefits package. Cambridge Health Alliance is an Equal Employment Opportunity employer, and women and minority candidates are strongly encouraged to apply. CV & letter to Susan Lewis, Department of Psychiatry, 1493 Cambridge Street, Cambridge, MA; Fax: 617-665-1204. **Email preferred:** SLewis@challiance.org.

### Harrington Healthcare System

**OUTPATIENT/ADULT or CHILD CITY COMPENSATION/COUNTRY LIVING!**

Harrington Hospital seeks a Full-Time Outpatient Adult or Child Psychiatrist to join our psychiatric team of physicians, licensed therapists and an advanced clinical nurse specialist. We offer excellent working conditions and a supportive staff with nursing staff available for med calls and other psychiatrists available for vacation coverage. We are opening new sites and expanding our services in Southern Worcester County.

Harrington Hospital is a 114 bed acute care independent, community hospital located in South Central Massachusetts with clinics located in Charlton, Southbridge and Webster. We are a teaching affiliate for the University of Massachusetts and St. Elizabeth’s. Our community is small, friendly, and safe with great schools, low cost of living, and beautiful countryside.

**Requirements:** MA license or license eligible; Board Certified or Eligible

**Benefits include:** signing bonus, flexible schedule, free parking, collegial medical staff, EMR, CME Program, part-time positions also available.

Tom Trask, Executive Director Physician Services, 508-764-2424, ttrask@harringtonhospital.org

### Whittier Pavilion

**Weekend and Overnight Positions Available**

Whittier Pavilion is a 65 bed fully licensed free standing psychiatric hospital in the Merrimack Valley is recruiting psychiatrists to provide overnight, weekend, and holiday psychiatric coverage. On call shifts are 12 hours and paid at an hourly and per visit rate. Coverage includes psychiatric assessments of newly admitted patients on our Adult Psychiatry and Geropsychiatry Units and availability to address urgent clinical issues by phone.

Our facility is expanding services and programs and future employment opportunities may be available for clinicians who are dedicated to providing excellence in care and being a part of a multidisciplinary team on both our inpatient units and adult outpatient clinic.

For more information please email CV to Katherine Ruiz-Mellott, MD, MPH; kruizmellott@whittierhealth.com or call 978-556-6229.
The Fellowship is a 1-year ACGME approved program for a PGY V psychiatrist providing training in the delivery of psychosocial consultation in a community general hospital as well as to a culturally diverse array of patients in primary care clinics. Specialty training in Women’s Health, Addictions and Behavioral Medicine is also available. Cambridge Health Alliance’s unique blend of community and academic resources offers exceptional opportunities for professional growth. Responsibilities: direct patient care; supervision of psychiatry and primary care residents and medical students; developing an academic project. Contact Robert Joseph, MD, Director, Consultation-Liaison Psychiatry, 617-665-1544, email Robert_joseph@hms.harvard.edu, fax 617-665-2521.

The PINE Psychoanalytic Center is pleased to announce two fall programs.

**The Couch and the Cushion: What Psychoanalysis and Buddhism Can Learn from Each Other**

**Time / Date:** 10 a.m. – 4 p.m., Saturday, September 28, 2013

**Presenters:** Mark Epstein, Ph.D., Andrew Olendzki, Ph.D. and Sara Weber, Ph.D.

**Discussant:** Axel Hoffer, M.D.

**Location:** Pine Manor College, Ellsworth Theater

**Co-Sponsored by:** The Paul G. Ecker, M.D. Center for Interdisciplinary Studies, New England Foundation for Psychoanalysis, and the PINE Psychoanalytic Center

**Fees:** General $130, Early (before 9/9/13) $110, PINE members $90, Students $65, CME/CE credits for additional $30; lunch available for additional fee

**Action as Communication in the Psychoanalytic Process**

**Time / Date:** 1:30 p.m. – 4:30 p.m., Saturday, October 5, 2013

**Presenter:** Aisha Abbasi, M.D.

**Discussant:** Morris J. Stambler, M.D.

**Moderator:** Stephen D. Kerzner, M.D.

**Location:** Macht Auditorium, Cambridge Hospital, Cambridge

**Fees:** CME is free for PINE Center members $45 for non-members

For continuing education information, please call the PINE Psychoanalytic Center office at 781-449-8365. Visit our website at www.pineanalysis.org or call the PINE office for information.

**Medical Director – Boston**

Arbour Hospital is seeking a full time Medical Director to become an integral member of this 136 bed psychiatric facility’s Leadership Team. The ideal candidate will be Board Certified with Medical Director level experience and must have 5 or more years of experience in an inpatient behavioral health setting. This experienced, dynamic physician leader will oversee our OPPE and FPPE Joint Commission processes, our PI/Quality program, utilization review committee, and actively work with the CEO in physician recruitment/retention for medical staff. The successful candidate will have excellent interpersonal, written and verbal communication skills and a passion for providing excellent care in a cost effective, changing healthcare environment. The Medical Director will oversee our highly qualified Physician staff and have both administrative and clinical duties. Our excellent team of practitioners, clinicians, nurses and support staff provide quality treatment for adolescents and adults in outpatient, partial hospitalization and inpatient levels of care as well as electroconvulsive therapy for inpatients and outpatients. Arbour Hospital is an 118 bed located in the Jamaica Plain section of Boston and satellite The Quincy Center, is an 18 bed high intensity inpatient setting in Quincy, MA. As well, the hospital has an outpatient program with a spectrum of outpatient mental health and substance abuse services located in a separate office building off of the main campus in Jamaica Plain. The service are accredited by The Joint Commission and licensed by both the MA Department of Mental Health and Department of Public Health Bureau of Substance Abuse Services.

Because we have physicians on site 24/7, there is no routine weekend or week-end call requirement.

The Medical Director position comes with a very competitive compensation package of salary, benefits, including paid time off, CME and malpractice reimbursement and opportunity to earn additional income. For more information on this position, please contact: Andree Paige, In-House Physician Recruiter, Arbour Health System Tel (617) 390-1437, Cell (617) 429-4240, Fax (617) 390-1576 Email andree.paige@uhsninc.com

**RNCS/APRN/MD**

**Servicenet Mental Health Centers**

**Greenfield/Northampton**

*We are an innovative, quality driven behavioral health organization dedicated to excellence. If you enjoy working as a team with dedicated professionals and making a difference in the lives of those we serve, then this is the position you have been looking for.*

**RNCS/APRN/MD:** Treating Adults at our Greenfield/Northampton Outpatient Mental Health Centers. Part time or fee for service positions available; pay commensurate with experience.

For inquiries, please contact Skip Soper, LICSW at 413-585-1363

**To apply:** Please download an application from our current openings page at servicenet.org. Send completed application with resume and cover letter citing Search #409MPS to jobs@servicenet.org or servicenet, Human Resources, 296 Nonotuck St, Florence MA, 01062

**AA/EEOC/Tobacco Free**
Full-time, salaried psychiatry position available on the 22-bed, general adult inpatient psychiatry unit at Melrose-Wakefield Hospital, a full-service community hospital 8 miles north of Boston.

On-call coverage is optional. The adult unit is part of Hallmark Health’s comprehensive behavioral health service that includes geriatric inpatient units at Lawrence Memorial Hospital in Medford, ECT, and outpatient services at Community Counseling in Malden and Medford. Voted One of Boston Magazine’s Best places to work in Boston, we offer a competitive compensation and benefits package and flexible schedule. Tufts faculty appointment available. Current MA professional license is preferred.

Please send CV to Gina Mariona at gmariona@hallmarkhealth.org.
www.hallmarkhealth.org

WORCESTER, The University of Massachusetts Medical School is seeking a psychiatrist with a career interest in Public Sector Psychiatry for a position at Worcester Recovery Center and Hospital (WRCH). WRCH, a state-of-art inpatient and rehabilitation facility that opened in October, 2012, is a short walk from the Medical School so research and teaching opportunities are easy to accommodate and actively encouraged. This public psychiatric hospital is unique with person-centered, recovery-foci as fundamental, operative principles. The successful candidate must be BE/BC and preferred training/experience in Public Sector Psychiatry. Faculty appointment at appropriate rank, competitive salary and excellent benefits. Interested applicants should apply at: www.academicjobsonline.org

HIGH POINT TREATMENT CENTER is seeking the following:

- **Full Time Psychiatrist** to allocate hours in a 19 bed Inpatient Psychiatric Unit and Outpatient Services located in Plymouth, MA (relocating to Middleboro, MA in the Summer/Fall of 2014);

- **Psychiatrists** for a **NEW** 72 bed Adult / Adolescent Inpatient Psychiatric Unit opening in Summer/Fall of 2014 located in Middleboro, MA; and

- **Full Time/Part Time Psychiatrists** to allocate hours in both Inpatient and Outpatient Services with offices located in New Bedford, Taunton, and/or Plymouth, MA.

Excellent health benefits available. Paid leave time of 18 days in the first year, 21 days in the second year, 24 days in year 3 and 30 days once you have five years. Holiday time is 11 days. Retirement Plan 403b.

If interested, please contact Jim Horvath at 508-408-6155 or email to jhorvath@hptc.org

- Also available Doctor on Call weekday, weekend and Holiday coverage – for the Plymouth Inpatient Psychiatric Unit.

If interested, please contact Mark J. Hauser, M.D. at 617-969-6331 or email to hausermd@psychiatry.com

WORCESTER, The University of Massachusetts Medical School is seeking a psychiatrist with a career interest in Public Sector Forensic Psychiatry for a position at Worcester Recovery Center and Hospital (WRCH). WRCH, a state-of-art inpatient and rehabilitation facility that opened in October, 2012, is a short walk from the Medical School so research and teaching opportunities are easy to accommodate and actively encouraged. This public psychiatric hospital is unique with person-centered, recovery-foci as fundamental, operative principles in serving civil and forensic patients. The successful candidate must be BE/BC and preferred training/experience in Forensic Psychiatry. Faculty appointment at appropriate rank, competitive salary and excellent benefits. Interested applicants should apply at: www.academicjobsonline.org
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<tr>
<th>Event</th>
<th>Date and Time</th>
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<th>Contact Email</th>
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<tr>
<td>Chairs and Council</td>
<td>September 10, 2013 at 7:00 PM</td>
<td>Mass Medical Society, Waltham</td>
<td><a href="mailto:bdupuis@psychiatry-mps.org">bdupuis@psychiatry-mps.org</a></td>
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<td>Managed Care</td>
<td>September 17, 2013 at 7:00 PM</td>
<td>MPS</td>
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<td>MPS Organizational Psychiatry</td>
<td>September 18, 2013 at 6:30 PM</td>
<td>MPS</td>
<td><a href="mailto:bdupuis@psychiatry-mps.org">bdupuis@psychiatry-mps.org</a></td>
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<tr>
<td>“What is Organizational Psychiatry?” — Dr. Ken Settel</td>
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<td>Public Sector</td>
<td>September 19, 2013 at 7:00 PM</td>
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<td>Committee for Women</td>
<td>September 20, 2013 at 12:00 NOON</td>
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<td><a href="mailto:jkealey@psychiatry-mps.org">jkealey@psychiatry-mps.org</a></td>
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<td>Professionalism and the Internet: Clinical, Legal and Ethical Issues</td>
<td>September 21, 2013 from 8:30 AM – 12:45 PM</td>
<td>Mass Medical Society, Waltham</td>
<td><a href="mailto:jkealey@psychiatry-mps.org">jkealey@psychiatry-mps.org</a></td>
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<td>in Psychiatric Practice</td>
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<td>Executive Committee</td>
<td>September 24, 2013 at 7:00 PM</td>
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<td>Geriatric Committee Meeting</td>
<td>September 25, 2013 at 8:00 PM</td>
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<tr>
<td>“From the Battlefront to the Homefront: The Experience of a Military</td>
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<td>and Veterans Psychiatrist” — Dr. John Bradley, Speaker</td>
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<td>Consultation—Liaison Committee Meeting</td>
<td>October 3, 2013 at 7:00 PM</td>
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<td>“Medical Cannibas in MA” — Dr. Manuel Pacheco</td>
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<td>24th Annual Psychopharmacology Update</td>
<td>October 5, 2013 at 8:00 AM</td>
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<td>Council</td>
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<td>APA Institute on Psychiatric Services</td>
<td>October 10–13, 2013—Philadelphia, PA</td>
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<td>Managed Care</td>
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<td>MPS</td>
<td><a href="mailto:bdupuis@psychiatry-mps.org">bdupuis@psychiatry-mps.org</a></td>
</tr>
<tr>
<td>Executive Committee</td>
<td>October 22, 2013 at 7:00 PM</td>
<td>MPS</td>
<td><a href="mailto:bdupuis@psychiatry-mps.org">bdupuis@psychiatry-mps.org</a></td>
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