Folks,

Back to a topic in the last Sentinel, a lack of continuity between inpatient and outpatient, a lack that may be lethal. While continuity is championed, about half of patients leaving their inpatient unit were not scheduled to see anyone within a week of discharge. One third were not scheduled to see anyone within a month. In the 1990s at the NVMHI, we attempted to solve this by transporting the patient to the follow-up clinic at the time of discharge, and ask relatives to pick up the patient at that clinic, not at the hospital. Seemed simple, but it was not a huge success, as I underestimated the difficulties of the ward at NVMHI, the relevant clinic, and relatives all agreeing on the exact time to discharge the patient.

Recent articles I think are not complete as to FDA approved for mania. I think the following is complete:

1] Aripiprazole
2] Asenapine
3] Carbamazepine
4] Chlorpromazine
5] Lithium
6] Olanzapine
7] Quetiapine
8] Risperidone
9] Valproate
10] Ziprasidone

If I am missing an FDA approved med for mania, please let me know.

As to advising your patients wanting to lose weight, a study of people wanting to lose weight volunteered for a weight loss program in which half used arm monitoring devices that tracked steps taken per day. After two years those who used the arm devices lost eight pounds. Those who did not use the devices, to the surprise of the researchers, lost more, thirteen pounds. [This research limited its upper age to 35, believing that those of us older than 35 might be incompetent in using such technology.]

The number of emergency department (ED) visits due to adverse reactions with the insomnia drug zolpidem (Ambien) increased 220% between 2005 and 2010. The largest increases were among women and the elderly, 2 groups known to be more sensitive to the drug's effects.

You may have seen the headline that female physicians earn $18,000 less than male physicians because they code at a lower level. Article surveyed thirteen medical specialties, but not psychiatry -- even though we are one of the larger specialties.

While people seeking resources for borderline personality disorder (BPD) appear to be aware of evidence-based therapies to treat BPD, stigma associated with the disorder

and the cost of treatment remain significant hurdles to care, according to a report published last Wednesday in Psychiatric Services in Advance. An impediment not fully addressed is that some prospective patients have concluded, after doing a search, that they need dialectal behavior therapy, which can be hard to find – not aware that guidelines say that DBT is only superior in those with suicidal ideation.

An article in this month's Psychiatric Services concluded that practitioners are adequately prescribing for SSRIs, but inadequately prescribing tricyclics, prescribing less medication than recommended.

Also in this month's Psychiatric Services, this conclusion on coercive treatment: "Coercive treatment can be justified only when a patient's capacity to consent is substantially impaired and severe danger to health or life cannot be prevented by less intrusive means."

A survey of a million females in Denmark, a survey to be published in AMA Psychiatry that received a lot of media attention, concluded that there is an increased risk for use of an antidepressant medication among users of different types of hormonal contraception. Restated, study suggested depression as a potential adverse effect of hormonal contraceptive use. Not easy to rule out the question of whether being sexually active is associated with increased risk of depression.

Roger