The last meeting for Alex Lerman was the first meeting for me as President of Psychiatric Society of Westchester. The topic of discussion was access to mental health services and how that is endangered. There is a real shortage of psychiatrists in the metropolitan area. New graduates of residency programs are more likely to take positions with hospitals; none seem to be going into private practice. I suspect that this is in part due to horrific levels of debt that many residents have. Almost all of the residents I know are at least $250,000 in debt, and payments on those loans will fully kick in if they have not done so already. The ordinary tasks following residency—starting a career, moving into a new home, saving for family, a home school for any kids and retirement—also loom large. Inpatient positions are desperately needed, but filling these slots helps maintain present access levels but does not expand it.

We need more private practice psychiatrists in Westchester. The bulk of those that have been in private practice are aging and many are considering cutting back on their practices. However, there is no one to refer these patients to. Thus, there is a dovetailing of the needs of those reducing their practices with the needs of those setting up their practices.

One of the topics that I would like to address this year is showing residents and others about how to set up a private practice. The complexities of billing, insurance, offices, EMR, referral base, are difficulty to work out without a guide. We intend to help people in this endeavor and, in so doing, increase access to psychiatric services in Westchester County.

Report from the APA Assembly May 2019 Meeting

Reported by: C. Deborah Cross, M.D.

The APA Assembly met in San Francisco at the Annual Meeting of the APA from Friday, May 17 to Sunday, May 19, 2019. The usual format of the Assembly Meeting occurred with a mix of general sessions of the entire Assembly and breakout sessions of the various Councils (New York State is Area 2) and other separate group meetings such as specific Committees (e.g., Reference Committees, Procedures, etc.—more about some of them later), and Work Groups.

As I explained in my last report, the Assembly is the crucial link between the general membership of the APA and the Board of Trustees of the APA and the various other components of the APA. The Assembly “work product” is Action Papers, which, when passed, are then disbursed to appropriate leadership within the APA. The Assembly also reviews new and existing Position Statements of the APA. At this most recent Assembly, 16 new and existing Position Statements were reviewed. A few of the Position Statements which were reviewed this Assembly were the following:

Approved: Revised Position Statement “Against the Use of Cannabis for PTSD”

Approved: Revised Position Statement “Carve Outs and Discrimination”
Report from the APA Assembly May 2019 Meeting

(Continued from page 1)

Approved the retention of Position Statement Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients

Approved: Proposed Position Statement: Civil Commitment for Adults with Substance Use Disorders.

All of the above Position Statements were sent to the Joint Reference Committee (JRC) for its June meeting and then to be forwarded to the Board of Trustees for its July meeting. If any of you wish further information regarding any of these Position Statements (or some of the others not mentioned), please don’t hesitate to contact me. (All of these Position Statements had or will be reviewed by the various APA Councils/Committees, see below for further explanation.)

The Assembly also debated (both in the Reference Committees and the Council Committees) 45 Action Papers (a record number!). Some of the ones that seemed especially notable (at least to me) were some of the following:

“Development and Dissemination of Model Curricula on Climate Change and Mental Health”, passed and sent to the JRC.

“Collaborating to Improve Psychiatric Training in Family Medicine Residencies”, passed and sent to the JRC.

“Medical Supervision of Psychiatry Residents and Fellows”, passed and sent to the JRC.

“Improving Public Understanding of Psychiatry”, passed and sent to the JRC,

“Advancing Gender Equality in Medicine”, passed and sent to the JRC.

“A Feasibility Study for an Alternative Process for Specialty Certification”, passed and sent to the JRC.

“Psychiatry Residency Position Expansion”, passed and sent to the JRC.

Some explanation is needed as to the role of the JRC. The Joint Reference Committee acts as a “traffic controller” between the various entities within the APA. Besides the Assembly, there are many APA Committees which work on a multitude of issues affecting Psychiatry and Psychiatrists. (These Committees are called “Components” and members are appointed by the President of the APA in Collaboration with the Speaker of the Assembly—actually the process starts with the President Elect and the Speaker Elect, since many months are spent in this process.) When the Assembly passes an Action Paper on a topic which is also under the purview of a Committee (or a number of Committees, which make up a “Council”), the Action Paper would be sent to that Committee/Council for their input. An example would be if the Assembly passed an Action Paper stating that juveniles should not be sent to adult prisons. There is an APA Council on Psychiatry and Law with various Committees under that Council and the Paper would be “assigned” by the JRC to that Council/Committee to review and either “pass, revise or reject” with the understanding that collaboration between the Assembly and the reviewing Council/Committee would occur to ensure that the “will of the Assembly” was appropriately met. A report on such process would then be given back to the Assembly as to “what had happened to the Action Paper”!

There are 13 Councils in the APA listed below: (as you can see, virtually every topic of importance to psychiatry is covered):

Council on Addiction Psychiatry
Council on Advocacy and Government Relations
Council on Children, Adolescents, and Their Families
Council on Communications
Council on Consultation-Liaison Psychiatry
Council on Geriatric Psychiatry
Council on Healthcare Systems and Financing
Council on International Psychiatry
Council on Medical Education and Lifelong Learning
Council on Minority Mental Health and Health Disparities
Council on Psychiatry and Law
Council on Quality Care
Council on Research

Various Work Groups and Committees of the Assembly also met in May. Some of these Committees/Work Groups are: Public & Community Psychiatry, Committee on Access to Care, Committee on Maintenance of Certification, Work Group on Increasing Voter Turnout, and Committee on Psychiatric Diagnosis & the DSM. A brief word on the last Committee (since I just got appointed to it as the Area 2 representative). This is a liaison Committee between the Assembly and the various DSM Work Groups with the charge (as I understand it) of soliciting from APA

(Continued on page 6)
2019 Fall Teaching Day: Specialized Biological Treatments
Reported by Jerry Liebowitz, MD

On Saturday, October 13, The Psychiatric Society of Westchester presented its Fall Teaching Day at the Phelps Hospital Auditorium with three CME presentations.

After a refreshing breakfast buffet, our Program Chairman, Richard Gallagher, MD, welcomed everyone, noting the importance of the topic to all psychiatrists.

We had stimulating and informative presentations from Alexandra Burger, MD, who led a roundtable discussion on effective medications in treating substance abuse and addiction; Robert Ostroff, MD, who presented the history and current and future uses of ECT; and Michael Grunebaum, MD, who spoke about ketamine treatment.

The scheduled first speaker, Dr. Steven Ferrando, was unable to attend because of a family medical emergency. Alexandra Burger, MD, an addiction psychiatrist at the Hudson Valley VA Hospital, agreed to lead a “roundtable” discussion about addiction psychiatry and various treatments for addiction and substance abuse. She began by speaking about the opioid epidemic and important efforts to expand the use of Suboxone (buprenorphine/naloxone) to primary care, which so far have not been very successful. She also discussed the use of Vivitrol (naltrexone) in alcohol as well as opioid dependence. He stressed the importance of using Suboxone early in treatment in conjunction with other psycho-social treatments. For example, the medication could be started in the ER followed by a referral to a clinic. She supported waivers for short-term prescriptions followed by continued treatment with addiction specialists. To obtain a waiver and prescribe buprenorphine, physicians are required to complete eight hours of internet training.

Mark Russakoff, MD, then spoke about his experiences at Phelps, where not many opioid addicts are treated – perhaps, he opined, because of good methadone programs elsewhere – but where he sees patients addicted to or dependent on other drugs. He felt there should be a low threshold for Suboxone’s use and many more providers in the area.

Sally Ricketts, MD, from Montefiore (“ground zero” for the opioid epidemic), addressed the question of who are good candidates for Suboxone and what kind of treatment team is needed for optimal outcome. She noted that most of her work is with primary care clinics and that many patients come there because they heard of the Suboxone program. It is very important, she emphasized, that there be a navigator-type person to coordinate efforts, that agreements with patients are obtained, and that the best time to coach patients is when they are “in a little bit of withdrawal,” about 12 hours after their last dose.

The discussion then went to medication-assistance in reducing alcohol and tobacco use. The results have been excellent, especially with smoking. The importance of using a harm-reduction approach in medically ill patients, especially post MI, was emphasized, since abstinence may be unrealistic. And the much greater effectiveness of Chantix (varenicline) over nicotine replacement or bupropion was pointed out. For reducing alcohol dependence, the indications for and the use of Campral (acamprosate) and oral naltrexone was discussed in some detail. The potential role for Antabuse (disulfiram) was commented on, noting that it does nothing for cravings.

Richard McCarthy, MD, commented on the use of NAC to decrease marijuana cravings. He also reported that, when it was used as an adjunct to antidepressants, patients also incidentally stopped smoking marijuana.

The second presentation was by Robert Ostroff, MD, Professor and Director of the Mood Disorders Program at Yale Psychiatric Hospital. His talk was titled, “Electroconvulsive Therapy in the 21st Century: Where did we come from? Where are we going?” He explored the history of the use of ECT and explained why he believes that “modern ECT is underutilized.” It is a controversial treatment, he said, mainly because of stigma. But it is an important and cost-effective treatment, he noted, emphasizing that the over-all rate of remission using standard treatments is still under 70%. Looking at the economics of depression, he showed that of the $83 billion spent annually, only 31% is the cost of treatment (including $10.4 billion for pharmaceuticals). Lost productivity and lost workdays cost a combined total of $63.2 billion and mortality from suicide costs another $5.4 billion. He compared this to the markedly decreased rate of deaths from coronary heart disease since we

(Continued on page 4)
Dr. Ostroff noted that there are many serious disorders that respond well to ECT, including: Major Depressive Illness with psychotic features; Bipolar Disorder, depressed and manic (treatment resistant); Schizoaffective Disorder, depressed type; Schizophrenia – especially acute onset with confusion and as an augmentation agent; Catatonia, regardless of the underlying diagnosis; Parkinson’s Disease (bradykinesia, tremor, rigidity, gait disturbance, postural instability) and In Parkinson’s without depression.

He went on to describe the characteristics and seizure morphology of brief pulse stimulus ECT and why it is much safer than the old sine wave ECT. The mortality rate, he noted, was only 0.006%, comparable to that of good anesthesia.

Post-ictal Cognitive impairments include retrograde amnesia for events nearest to time of treatment and anterograde amnesia (up to 6 months post-treatment in some studies). Bilateral ECT causes greater cognitive impairment. And interictal delirium is a complication that is greatest in the elderly and can be reduced by decreasing frequency and using unilateral ECT.

ECT stresses the heart and raises CSF pressure. Cardiac complications include hypertension and abrupt rate transitions that can result in arrhythmias. Modifications to avoid these complications include pretreatment with atropine or glycopyrrolate or pretreatment with labetalol and/or nifedipine.

Dr. Ostroff concluded by emphasizing the following observations: 1) ECT is a safe and very effective treatment for depressive disorders, either first-line treatment or after medications fail; 2) Between 80-90% of patients will respond to ECT; 3) It is the most efficient and fast-acting treatment for urgent-care, severely depressed patients, for whom medications take 4-6 weeks to work; 4) It is the treatment of choice for catatonia, failure-to-thrive, and psychotic and suicidal depression; and 5) Although there is a 55% relapse rate with ECT, so-called “maintenance ECT” is often helpful, and during such a continuation phase, the interval between treatments can slowly be increased.

After a break for lunch, the third presenter was Michael Grunebaum, MD, Special Lecturer at Columbia University and
YOUR
SPECIALIZED PRACTICE
IS SAFE WITH US

WE PROTECT YOU
PRMS understands that each psychiatric specialty possesses its own unique set of challenges. Our medical malpractice insurance program is tailored with rates that reflect your specific risks and expert risk management materials relevant to your specialty.

VICTORIA WATKINS, RPLU
ASSISTANT VICE PRESIDENT, INSURANCE SERVICES

Specialty-specific protection is just one component of our comprehensive professional liability insurance program. When selecting a partner to protect you and your practice, consider the program that puts psychiatrists first. Contact us today.

More than an insurance policy
(800) 245-3333 | PRMS.com/Dedicated | TheProgram@prms.com

Actual items, coverages, conditions and exclusions may vary by state. Insurance coverage provided by Felt American Insurance and Reinsurance Company (NAIC 39207). FAIRCO® is an authorized carrier in California, ID number 37551. www.Fairco.com.
members any concerns, comments, etc. about various topics covered in the current DSM (5), to pass along to the DSM Work Groups currently working on revisions. As most of us know there is always some controversy around various diagnostic categories, wordings, etc. At the meeting of this Committee in May one of the members brought up concerns that a number of child psychiatrists are having with the new Autism Spectrum Disorders and the specific issues and comments will be collated and given to the DSM Task Force. I urge any of you who have issues such as these with DSM to contact me prior to the November meeting.

The May Assembly meeting was busy, active and fruitful. The next Assembly is in mid-November and there will be more news to come. Please don’t hesitate to contact me at any time with questions or ideas about your APA and the work of your Assembly. ■

C. Deborah Cross, MD
APA Assembly Rep, Psychiatric Society of Westchester
deborahcross@usa.net

2019 Fall Teaching Day: Specialized Biological Treatments

Research Psychiatrist at the NY State Psychiatric Institute, who spoke on “Ketamine Treatment – Hype or Here to Stay?” He began by discussing the current “hype” and excitement about ketamine, referencing a NY Times Sunday Review opinion article (12/2/2018) titled, “Can We Stop Suicides?”, which said, “It’s been way too long since there was a new class of drugs to treat depression. Ketamine might be the solution.” He then pointed to the Columbia Ketamine Program (which uses it IV and off label), which advertises: “Faster relief from depression. Now available from leaders in the field.”

Grunbaum’s goal, he stated, was to present more balanced clinical psychopharmacology research perspective, focusing on the reasons for the current interest in psychiatric ketamine, a review of clinical trials for suicidal ideation (SI), and a discussion of possible next steps. The “bottom line,” he noted, based on his perspective after supervising over 100 ketamine infusions, is that ketamine has remarkable “Awakenings-like” effects for some patients but is not “the solution” (as hyped in the NYT’s article). Additional infusions are needed to maintain the effect, and little is known about the safety and efficacy of long-term use. Treatment-resistant depression remains a problem. A realistic hope is that understanding ketamine’s mechanism will lead to new, safer drugs. It is, however, a potentially useful intervention in certain settings with appropriate consent and precautions.

Grunbaum then turned to ketamine’s history and pharmacology, noting that it was initially synthesized for anesthesia by Parke-Davis in 1962 and approved by the FDA in 1970. Ketamine inhibits glutamate NMDA receptors (in contrast to current antidepressants, which act on monoamines) but also affects other receptors, including dopamine and opioid. It was a popular drug of abuse (“Special K”) because of its “dissociative” effects (spacy, weird feelings, etc.). Chronic heavy use can cause serious injury to the brain and bladder.

He went on to describe in some detail the use of ketamine for depression. The standard dose for IV infusion (0.5mg/kg/40 minutes), which is 5-25 times lower than that used for anesthesia, leads to an antidepressant effect in a few hours. However, the antidepressant effect lasts about one week. Other routes have also been shown to be effective, including intranasal. Esketamine nasal spray was recently approved by the FDA. Although we do not clearly understand how ketamine works in depression, a leading theory of its mechanism is that it causes a rapid increase in synaptic plasticity via glutamate pathways (with decreased NMDA and increased AMPA) and increases in brain-derived neurotropic factor (BDNF) and GABA. Interestingly, he noted, naltrexone interferes with this effect. Grunbaum questioned whether that could mean that ketamine’s effect is opioid-mediated.

Ketamine has been used psychiatrically for decades. For example, a report in Psychosomatics in 1973, described a study in which psychiatric inpatients in Iran with a variety of diagnoses were administered ketamine and most had a minimal anesthetic response as well as an abreactive response, which “facilitated their psychotherapy and symptom relief.” And the antidepressant effects of a ketamine-like anti-TB drug, cycloserine, have also been long known since the early 1960s.

The recent interest in ketamine as an antidepressant is based on...
Psychiatrists Professional Liability Insurance

Discounts Offered Include:

- **15% NEW POLICYHOLDER DISCOUNT** (must be claims free for the last 6 months)
- **Up to 50% New Doctor Discount** (for those who qualify)
- **10% Claims Free Discount** (for those practicing 10 years, after completion of training, and remain claims free)
- **50% Resident-Fellow Member Discount**
- **15% Child and Adolescent Psychiatrist Discount** (for those whose patient base is more than 50% children and adolescents)
- **50% Part-time Discount** (for up to 20 client hours a week or less)
- **5% Risk Management Discount** (for 3 hours of CME)

*Where allowable by law and currently not available in AK or NY. (Above Discounts and Coverage Features are subject to individual state approval.)*

For over 40 years we have provided exceptional protection and have a reputation for outstanding customer service. Our extensive years of experience and industry knowledge allows us to help you by providing worry free coverage so you can concentrate on what you do best – helping people help themselves. When it comes to caring about people, we have a lot in common.

Our Psychiatrists Professional Liability Program Provides:

- Limits up to $150,000 in Defense Expenses related to Licensing Board Hearings and other Proceedings
- Up to $150,000 in Fire Legal Liability Coverage
- Up to $100,000 in Medical Payments for Bodily Injury
- Up to $25,000 for First Party Assault and Battery Coverage
- Up to $25,000 for Information Privacy Coverage (HIPAA)
- Up to $15,000 in Emergency Aid Coverage
- Insured’s Consent to Settle required in the settlement of any claim – No arbitration clause
- Telepsychiatry, ECT, Forensic Psychiatry Coverage
- Risk Management Hotline with 24/7 Service for Emergencies

Visit us at apamalpractice.com or call 877.740.1777 to learn more.
two main issues, according to Grunebaum: treatment resistance
and the fact that, despite an increase in antidepressant use of
65% since 1999, suicide rates have increased 25% from 1999–
2016. And because of this and an increase in opioid deaths, US
life expectancy has declined. An announcement last year by R.
Redfield, MD, Director of the CDC, stated, “... these sobering
statistics are a wakeup call that we are losing too many
Americans, too early and too often, to conditions that are
preventable...” In parallel, Pharma companies have reduced
psychiatric drug research for the next Prozac. An article in The
Guardian in January 2016 noted that large placebo effects
have led to failed trials, so there has been “nothing particularly
novel in a long time.”

Grunebaum noted that a renewed interest in ketamine was
spurred on when trials at Yale (Berman 2000) and NIMH (Zarate
2006) showed a rapid antidepressant effect, help with treatment
-resistant depression (TRD), and a reduction in suicidal ideation.
This led to ketamine clinics across the country, although we still do
not know if repeated injections will be safe and effective.

He then discussed the reasons for his randomized clinical trial
(RCT) of ketamine for suicidal Major Depressive Disorder
(MDD). Some of the background rationale for the study included
several observations: there is little data to guide the medical
management for suicidal patients; suicidal patients have
historically been excluded from RCTs; suicidality is urgent, but
antidepressants take weeks to relieve MDD and SI; and
depression predicts suicide attempts partly via suicidal ideation.
In addition, he pointed out, there were several limitations of the
initial studies of ketamine for suicidal ideation, including no
control condition or saline control, using only one scale item for SI,
using patients with only mild SI, and including patients with mixed
diagnoses.

He went on to describe in some detail the methods of his
randomized, midazolam-controlled clinical trial that avoided
these limitations and required inpatient infusions. Eighty patients
were enrolled, of whom 54% were taking antidepressants at
baseline. Its primary outcome measure was an SSI score at 24h
post-infusion (Day1). Remission was defined as at least a 50%
decrease in SSI and an SSI<4. Non-remitters at Day1 were
unblinded after ratings and offered open ketamine if they had
been randomized to midazolam. After Day1, there was a
period of optimized med management for 6 months. Research
ratings were obtained for 6 weeks in observational follow-up
without a control condition.

The outcome results were impressive. Adjusted for baseline, day1
SSI was 4.9 pts lower after ketamine vs midazolam (p=0.0003;
d=0.75). Including BPD had little effect. The day1 response to
ketamine vs midazolam was 55% vs 30% (OR=2.9; p=0.02;
NNT=4). Thirty-five midazolam non-remitters received open
ketamine. The benefit was maintained in the 6-week
observational follow-up with optimized standard medication
treatment. An increase in SSI at Day1 was found in 2 ketamine
patients vs 9 for midazolam.

Grunebaum asked, is this clinically meaningful? In past
decades, RCTs show only an average 3-point advantage of
antidepressants over placebo on measures of suicidality on the
HAM-D. The UK National Institute of Health and Care Excellence
considers d≥0.5 or 3-point between-group difference on HAM-D
clinically to be clinically significant.

He described the Profile of Mood States scale (POMS), which is
more suited to a 24-hour time frame than the HAM-D. He
observed that the POMS Depression subscale favored
ketamine (p=0.02) as did the Fatigue subscale & POMS Total
score. Yet the POMS Depression score mediated only 34% of the
ketamine effect on suicidal ideation. This suggests that the
ketamine effect on SI is at least partly independent from its
overall antidepressant effect.

It was important to note, Grunebaum suggested, that ketamine’s
dissociative and other side effects resolved rapidly, so that the
blind appeared to be intact, since there was no significant
difference in correct guessing of the randomized drug.

Grunebaum then discussed the safety results of ketamine
infusion. He noted first that ketamine caused mean elevations of
15 points SBP and 13 points DBP, with a mean of 5 minutes to
return to baseline post-infusion. There were no signs of ketamine
abuse in f/u assessments at 3 and 6 months. Post-study, five
patients received ketamine off-label in clinics. During the study,
SAEs included 4 suicide attempts without serious medical injury
and 3 psychiatric admissions for increased SI.

In addition to a reduction in SI, Overall Cognition improved
more at Day1 after ketamine compared to midazolam. Patients
reported subjectively clearer cognition and better attention, e.g.,

(Continued on page 9)
some were able to read again. Differential drug effects in specific domains included reaction time, cognitive control, and memory.

Looking for exploratory biomarker assays, there were no clearly significant results, including saliva cortisol awakening response (CAR), BDNF in plasma/serum, BDNF val66met genetic polymorphism, or ketamine and metabolites in plasma.

Grunebaum himself noted several limitations of the study: there was no distinction between suicidal ideation and suicidal behavior; bipolar disorder was not evenly distributed at baseline; there was open treatment and no control group for the 6-week follow up ratings; and there were more dissociative effects with ketamine than midazolam.

In addition to his study, Grunebaum discussed other preliminary work on ketamine, including a pilot midazolam-controlled randomized clinical trial in bipolar depression with suicidal thoughts that showed a reduction in SSI 5.8 pts more after ketamine vs midazolam (p=0.07). He also described pilot MRI trials for later funded studies, including one with findings that resulted in the authors questioning whether ketamine’s effect could be related to increased synaptic density.

Grunebaum then presented a hypothetical model of neural correlates of ketamine’s effects on SI improvement, including decoupling of the hippocampus with midline anterior and posterior Default Mode Network (DMN). It has been postulated that elevated DMN connectivity is associated with depressive rumination, which is a risk factor for suicidal ideation and behavior. It may also result in possible modulation of limbic overactivity seen in mood disorders. A pilot in vivo proton magnetic resonance spectroscopy study of amino acid neurotransmitter response to ketamine treatment of major depressive disorder showed rapid increases in glutamate and GABA during ketamine treatment of MDD, and GABA is known to be a major inhibitor in the brain. In addition, new pilot studies of PET scans pre- and post-ketamine are planned, using a new radiotracer to provide a measure of synaptic density in vivo in the human brain.

The next steps for ketamine research, according to Grunebaum, should include: a definitive RCT in bipolar depression; a study utility in emergency departments of inpatient units for the rapid treatment of suicidal states; determining the safety and efficacy of long-term use; and elucidation of the therapeutic mechanism to develop new and safer drugs. New treatments are needed, in part, because depression is so heterogeneous.

Grunebaum concluded by noting that ketamine may be a useful addition to depression treatment, especially in severe cases such as suicidal and treatment-resistant depression. However, appropriate caution, monitoring, and informed consent are necessary. And more research – clinical and mechanistic – is needed.

CLASSIFIEDS

White Plains: Fully furnished, part time or full time office space available in a nicely renovated office suite. Large waiting area shared with mental health professionals. Ample parking. Centrally located.

Contact: Jonathan Sinowitz, Psy.D: 914-946-4466 Ext 1501
INTERESTED IN WRITING AN ARTICLE?
LETTER TO THE EDITOR OR AUTHOR?
HAVE A CLASSIFIED YOU WOULD LIKE TO INCLUDE?

Contact Megan Rogers to have your article, classified or opinion featured in our next newsletter!

centraloffice@wpsych.org or (914) 967-6285

We’re On The Web!
www.wpsych.org

https://www.facebook.com/PSWinc

The Psychiatric Society of Westchester County
400 Garden City Plaza, Suite 202
Garden City, New York 11530
T: (914) 967-6285
F: (516) 873-2010
E: centraloffice@wpsych.org