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"see" references are found on these pages:
4, 13, 14, 18, and 22
(These link to other items or a chart in the issue.)

Government News

House Passes Patients' Bill of Rights With Controversial Lawsuit Provisions

The House narrowly passes a patients' bill of rights that has more restrictive provisions than the Senate version. Before it was amended, APA had supported the bill.

BY CHRISTINE LEHMANN

When the House and Senate meet in conference committee next month to reconcile their respective versions of a patients' bill of rights, the most contentious issue will be the different lawsuit provisions.

Sens. Edward Kennedy (D-Mass.) and John Edwards (D-N.C.), cosponsors of the bill that the Senate passed in June (S 1052), have denounced the amended language in the House bill (HR 2563) that passed by a narrow margin earlier this month.

Although both bills provide similar new rights to health care coverage, a key difference is how violation of these rights could be adjudicated in state and federal court.

The House amendment offered by Rep. Charles Norwood (R-Ga.) just days before Congress recessed in early August would create a new federal legal rule for patients to sue their health plans in state courts dictating damage awards, standards of proof, and other terms, according to the legislation.

Kennedy and Edwards complained that the amended House bill limits pain and suffering damages in state and federal court to $1.5 million and punitive damages in state court to $1.5 million. The Senate bill allows patients to sue for unlimited pain and suffering damages and punitive damages of up to $5 million in federal court.

Although both bills require that patients go through an external review board before filing suit, under the House bill patients must meet a higher burden of proof if they lose the appeal.

The Senate bill (*see box on page 25*) creates no new federal rules spelling out the conditions under which patients can sue in state court and defers to state law for any caps on damages.

Cosponsors of HR 2563, Reps. Greg Ganske (R-Iowa), John Dingell (D-Mich.), and Marion Berry (D-Ark.), also criticized the Norwood amendment. They warned

see ***Bill of Rights*** *on page 25*

Rep. Greg Ganske (R-Iowa, at microphone) addresses a rally on the Patients' Bill of Rights on Capitol Hill last month. He was joined by APA President Richard Harding, M.D. (center), Donald Palmisano, M.D., of the AMA (in white jacket), APA Medical Director Steven M. Mirin, M.D. (far right), and Rep. Marion Berry (D-Ark., behind Ganske). The rally took place before Charles Norwood (R-Ga., standing next to Harding) reached a controversial agreement with President George W. Bush that significantly altered the House bill.

Association News

Florida Becomes Third State To Witness End of Ritalin Suit

One by one the lawsuits against APA and Novartis charging that they conspired to promote the ADHD diagnosis and boost sales of the company's drug Ritalin are falling by the wayside.

A class-action lawsuit filed in Florida against APA and Novartis Pharmaceuticals has come to a dead end, a fate it now shares with similar suits in California and Texas.

In Florida the plaintiffs who initiated the litigation withdrew their suit before a judge had the opportunity to rule on its merits. In California and Texas, where federal judges questioned the charges contained in the suits on both statutory and procedural grounds, the judges dismissed the suits before they could proceed to trial (*Psychiatric News*, May 18; June 15).

The Florida plaintiffs informed the court on July 5 that they planned to withdraw their suit, which was filed last November.

In all three suits, parents who purchased Ritalin (methylphenidate) for children who had been given an ADHD diagnosis alleged that APA developed the diagnosis of attention deficit disorder—and later attention deficit/hyperactivity disorder—for its *Diagnostic and Statistical Manual (DSM)* in an overly broad manner and then conspired with Novartis and the consumer advocacy group Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD) to promote the diagnosis. They charged that the organizations were motivated by a desire to boost sales of Ritalin, which for many years was the only form of methylphenidate available in the U.S. market.

Nearly identical suits are still active in Puerto Rico, where APA and other defendants are waiting to hear the results of a motion to dismiss, and in New Jersey, where a motion to dismiss will be filed by APA

see ***Lawsuits*** *on page 28*

Connecticut Bars Teachers From Recommending Psychiatric Drugs

Connecticut enacts a law that bars school personnel from recommending to parents that their children should begin taking a psychostimulant for ADHD—or, for that matter, any psychiatric drug.

BY KEN HAUSMAN

Teachers in Connecticut who recognize signs of attention deficit/hyperactivity disorder (ADHD) in the children they teach had better watch carefully what they say to parents about addressing the problem from now on.

In June the state became the first in the nation to regulate what teachers, guidance counselors, and other school personnel can recommend in response to children they believe have ADHD. They are specifically prohibited from recommending that students might benefit from methylphenidate (Ritalin) or other related psychostimulants.

The bill, to which state lawmakers gave unanimous approval, also bars teachers and other school staff from recommending any other psychoactive drugs to parents of children showing behavioral problems or other signs of a mental disorder.

If school personnel believe that a child would benefit from psychiatric treatment, their permitted course of action is to recommend to parents that they have their son or daughter evaluated by a psychiatrist or other "medical practitioner." They will also be able, with the parents' or guardian's permission, to consult with a psychiatrist or mental health professional about a child's behavioral problems.

What they cannot do is tell parents that unless they arrange for their child to begin taking a particular medication, that child will not be allowed to remain in his or her current classes.

"Despite the attention the law has received nationwide, I believe its impact will be minimal," Connecticut Psychiatric Society President Brian Benton, M.D., told *Psychiatric News*.

"What it will do is encourage teachers to make recommendations for students to be evaluated by a professional if they see that one of their students is displaying behavioral problems. We hope that professional will be a psychiatrist," Benton said.

He noted that teachers probably have no business recommending specific medications in the first place and that this law places that responsibility in a strictly medical context, where it belongs.

The original version of the bill said that teachers can have no involvement in this issue at all, but negotiations between the Connecticut Medical Society (CMS) and the bill's authors softened that prohibition somewhat, which is reflected in the final language.

"There was some very good give and take on both sides" before the compromise wording was agreed to, explained CMS President and former APA Assembly Speaker Al Herzog, M.D.

"Despite the attention the law has received nationwide, I believe its impact will be minimal."

The new law, known as Public Act 01-124, instructs each local and regional board of education in Connecticut to adopt such a policy as soon as possible.

The statute also makes clear that a parent's refusal "to administer or consent to the administration of any psychotropic drug" to his or her child cannot be considered grounds for the state's child welfare department to take a child away from a parent's or guardian's custody, unless there is proof that the decision to refuse medication results in the child being neglected or abused.

Connecticut lawmakers reacted strongly to press accounts of children with minor behavioral problems being "drugged" after other attempts to control children's behavior failed to achieve the desired results. They were so convinced that an epidemic of unnecessary prescriptions for psychostimulants was occurring in their state that they passed the legislation unanimously, and it was quickly signed into law by Governor John Rowland.

On introducing the bill in the Connecticut House of Representatives, its chief sponsor, Rep. Lenny Winkler, who is an emergency room nurse, expressed her shock at the number of children in Connecticut who are taking psychoactive drugs.

"I cannot believe how many young kids

see ***Teachers*** *on page 29*

Better Communication System To Benefit Us All

BY RICHARD HARDING, M.D.

Psychiatrists know that clear communication is essential for an effective medical practice and for professional associations. A major objective of APA's recent reorganization was to develop a strengthened organization with streamlined and integrated business functions. During the last decade information technology has played an increasingly large role in determining how an organization conducts its business. The Board of Trustees, the Assembly, and APA staff have been concerned with the Association's lack of a clear strategic plan for its information systems that will direct our technology infrastructure.

During his presidential year, Dan Borenstein, M.D., appointed the Ad Hoc Work Group on Information Systems composed of information system–savvy members such as Drs. Ronnie Stangler, Norman Alessi, Joshua Freedman, Thomas Kramer, and Area 2 Trustee Herbert Peyser. Working closely with our information systems staff, the work group members surveyed the current status of our system and reported that it had a number of deficiencies that made it difficult for staff members and district branches to communicate effectively.

In March the Board of Trustees asked the work group to develop a long-term information-system strategic plan for APA. The work group noted that there is a large spectrum of users of this system, including the central office, district branches, and state associations, and that there was a lack of uniformity in what these users expected from the system in the areas of membership status, dues billing, dues processing, and other vital areas of Association business.

It became clear that to ensure a unified accurate and accountable information system, we needed to review and redesign our current system with the help of representation from the central office, district branches, and state associations. District branch executives from large and small district branches were asked to participate in this planning process along with the Work Group on Information Systems and APA staff.

In June the work group, after extensive study of our needs and capabilities, reviewed three options and presented a recommendation as to how APA's information system should be further developed and improved.

Option 1 was to upgrade the existing 12-year-old system by patching together old and new software programs that might quickly improve dues billing and processing but would not provide a fully integrated member-service environment for the future.

Option 2 was to replace the current system with an "off-the-shelf" data-management system with limited capacity for customization. We learned that all "off-the-shelf" systems would require some customization to make them compatible with the many specialized business rules and regulations APA and its district branches have developed through the years. This option was considered attractive by the Board and by the work group because it addresses more than the membership system and provides the potential for a fully integrated business environment, for example, meetings registration,

see ***From the President*** *on page 29*

APA Urges President to End Medicare's MH Discrimination

APA calls on President George W. Bush to add discriminatory copays and lifetime limits imposed on psychiatric treatment to the list of Medicare reforms he wants to enact.

BY CHRISTINE LEHMANN

Medicare should be reformed to do a better job of providing optimal care to seniors, testified Health and Human Services Secretary Tommy Thompson before the House Ways and Means Committee last month.

That was one of eight reform principles Thompson noted as part of President George W. Bush's effort to influence the debate in Congress over how to modernize Medicare.

Thompson also presented a new administrative initiative to give physicians and other providers more input into Medicare operations (see article below).

These are the other principles Thompson highlighted from the Bush administration's framework for strengthening Medicare:

- Beneficiaries should have the option of a subsidized prescription drug benefit.
- Beneficiaries should have better coverage for preventive care and serious illness.
- Beneficiaries and those approaching retirement age should have the option of keeping the traditional fee-for-service plan without changes.
- Beneficiaries should have better health insurance options—for example, ones that are similar to those available to federal employees.
- Medicare legislation should strengthen the program's long-term financial security.
- Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.
- Medicare should encourage high-quality health care for all seniors.

APA commended Bush in a letter last month for proposing Medicare reforms. APA President Richard Harding, M.D., agreed with Bush's statement in the framework released last month that "Medicare's outdated benefits package doesn't protect beneficiaries against the high costs of treating serious illness."

He noted this is particularly true of Medicare's "historic, discriminatory, and outdated coverage of mental illness."

Medicare patients pay a larger share of their psychiatric treatment costs out of pocket due to a 50 percent copayment requirement for outpatient psychiatric services. "All other Medicare Part B services require a patient copayment of 20 percent," wrote Harding.

> "Medicare's outdated benefits package doesn't protect beneficiaries against the high costs of treating serious illness."

Medicare also limits treatment in freestanding psychiatric hospitals to 190 days in a patient's lifetime, said Harding. "This creates coverage shortfalls for those Medicare beneficiaries whose serious mental illnesses require them to be hospitalized at various points in their lives. This arbitrary limit doesn't exist for general hospitals," wrote Harding.

He called on Bush to help millions of Americans with mental illness by supporting efforts to reform these discriminatory features. Harding referred to the legislation introduced by Rep. Marge Roukema (R-N.J.) in February (HR 599) and Sens. Olympia Snowe (R-Maine) and John Kerry (D-Mass.) in May (S 841) that would repeal the 50 percent copayment for outpatient psychiatric services (*Psychiatric News*, June 1).

The Medicare Mental Illness Nondiscrimination Act had 54 cosponsors in the House and two in the Senate at press time.

"Enactment of this change would simply require our patients to pay the same 20 percent copayment they would otherwise pay if they saw their internist for the flu, their endocrinologist for diabetes, or their cardiologist for heart disease," wrote Harding.

He commended Bush's principle that Medicare should provide better insurance options similar to those available to federal employees. "We agree, and draw your attention to the fact that the Federal Employees Health Benefits Program now requires parity coverage of treatment for mental illness," continued Harding.

He also commented on Bush's principle that all seniors should have an optional subsidized prescription drug benefit. "Some of the most exciting and promising developments in prescription drugs relate to more effective pharmacotherapeutic treatment for mental illnesses such as depression, bipolar disorder, schizophrenia, and Alzheimer's disease."

Because 20 percent of seniors in the general population and 40 percent of seniors in primary-care settings experience symptoms of depression, having a prescription-drug benefit that provides greater access to medications would clearly benefit older and more disabled Americans, he stated.

"APA welcomes the opportunity to work with you to seize this historic opportunity to reform Medicare's outdated treatment coverage of mental illness," wrote Harding.

The president's "Framework to Strengthen Medicare" is available online at <www.whitehouse.gov/news/releases/2001/07/medicare.pdf>. ■

AMA Protest Convinces HHS Secretary To Review Usefulness of E&M Guides

HHS Secretary Tommy Thompson announces that he will reassess the process for revising Medicare's evaluation and management (E&M) documentation guidelines after an AMA-led coalition complains about numerous problems.

BY CHRISTINE LEHMANN

Burdensome, confusing, and flawed were some of the adjectives an AMA coalition of physician groups used to describe the latest attempt to develop new evaluation and management (E&M) documentation guidelines for the Medicare program.

APA and 38 other physician groups signed a June 29 letter from the AMA asking Thomas Scully, administrator of the federal government's Centers for Medicare and Medicaid Services (CMS), to reconsider the burden that the new guidelines and the "clinical examples" accompanying them would impose on physicians.

(The Centers for Medicare and Medicaid Services is the new name for the Health Care Financing Administration [HCFA].)

The AMA complained that the previous E&M guidelines issued in 1995 and 1997 have hindered rather than helped the delivery of appropriate patient care. The guidelines are intended to help physicians know how to bill Medicare for their patients' visits.

The AMA recommended that the clinical examples in the new draft E&M guidelines be scrapped because they are inconsistent, irrelevant to typical physician-patient encounters, and based on inappropriate clinical terminology. They also would require more documentation.

AMA called on CMS to reassess the need and value of having E&M documentation guidelines and clinical examples.

Apparently, the AMA letter had an impact because HHS Secretary Tommy Thompson announced in testimony last month before the House Ways and Committee and the Senate Finance Committee that he has put the draft E&M guidelines on hold.

"We had hoped that this current effort would reduce the burden on physicians, but it appears to need another look," testified Thompson. He asked Aspen Systems, the CMS contractor, to stop work on the current draft while CMS reassesses its effort.

Thompson said he is looking to the physician community to help design constructive solutions. "After six years of confusion, I think it makes sense to go back and re-examine the actual codes for billing doctors' visits," testified Thompson.

He mentioned that he looked forward to working with the AMA and other physician groups to simplify the codes and make them as understandable as possible.

To facilitate this process, Scully announced that a new physician committee will be formed and chaired by CMS Deputy Administrator Reuben King Shaw. This is one of seven health care committees that will meet monthly to "provide a better understanding of CMS and improve our policy feedback. The committees will also generate ideas for programs improvements and reform," said Scully in a statement last month.

The other six health care committees represent hospitals and rural health, nursing homes, health plans, nurses and allied health care professionals, home health and hospices, and dialysis centers. ■

Taxpayers May Gain New Option For Supporting Medical Research

A bill that the House of Representatives is expected to pass would allow federal taxpayers to contribute part or all of their tax refund to biomedical research conducted by the National Institutes of Health.

Federal taxpayers may have another choice next year of where they want their IRS overpayment to go automatically.

When taxpayers file their federal tax form, they may be able to designate any amount over $1 for biomedical research, if Congress passes the Biomedical Research Assistance Voluntary Option (BRAVO) Act. Taxpayers can already designate a specific dollar amount of their tax refund to be used for political election campaigns.

William Narrow, M.D., associate director of APA's Division of Research, told *Psychiatric News*, "This bill recognizes the enormous strides made by NIH in biomedical research over the last several years. Congress and the public realize that the taxpayers' donations will be put to good use by improving our understanding of medical illnesses, including psychiatric, and leading to better treatments."

The bill (HR 1340) was introduced in April by Rep. Michael Bilirakis (R-Fla.) and had 34 cosponsors at press time. Last month the House Energy and Commerce Health Subcommittee approved the measure, along with several other public health bills. The committee, chaired by Rep. Billy Tauzin (R-La.), is expected to approve the public health bills in the next few months.

HR 1340 would require the Secretary of the Treasury to transfer the taxpayers' contributions to the National Institutes of Health periodically. The proposed legislation prohibits the tax donations to be used to offset future congressional funding of NIH.

The text of the bill can be accessed on the Web at <http:\\thomas.loc.gov> by searching on HR 1340. ■

Correction

In the June 15 issue, the article "Evidence Based Medicine Aims to Improve Patient Care" stated that the model curriculum on psychopharmacology published by the American Society of Clinical Psychopharmacologists (ASCP) does not include medication guidelines or algorithms. The ASCP curriculum includes in its entirety the Texas Medication Algorithms Project. *Psychiatric News* regrets the error. ■

Medicare Too Adversarial, APA Tells Congress

APA recommends several Medicare reforms that might persuade more physicians to continue treating Medicare patients.

BY CHRISTINE LEHMANN

How physicians feel about Medicare was summed up at a congressional hearing last month titled "The Regulatory Morass at the Centers for Medicare and Medicaid Services (CMS): A Prescription for Bad Medicine."

The management of Medicare by CMS, formerly known as the Health Care Financing Administration, has come under intense scrutiny by Congress this year. The House of Representatives' Small Business Committee, chaired by Donald Manzullo (R-Ill.), held three hearings on the regulatory problems at CMS in July. APA submitted a written statement for the second hearing on the regulatory morass.

Health care clinicians and health care organization representatives testified at the first two hearings, and CMS Administrator Thomas Scully testified at the last hearing.

APA Medical Director Steven Mirin, M.D., said, "Our physicians in the field and patients they serve feel they are under siege by a Medicare administration that is too often unresponsive, insensitive, and hostile."

Mirin blamed much of the problem on the autonomous nature of CMS insurance carrier operations. Medicare uses roughly 24 private contractors (carriers) to administer Part B claims, and they are encouraged to develop their own local medical review policies (LMRPs). These are the criteria and standards for determining whether a service is covered, reasonable, necessary, and appropriate, said Mirin.

The LMRPs create widespread variation between carriers in the treatment of claims and often restrict or conflict with national Medicare coverage policy.

For example, patients with a primary diagnosis of Alzheimer's disease are entitled to psychiatric services according to the *Medicare Carrier Manual*, but several carriers have routinely denied these services, according to Mirin.

APA members have also reported that some carriers deny claims for family therapy, another covered service under Medicare.

Local carriers are also increasingly developing LMRPs that subject all claims above a set number, usually 20, to an intensive review, according to Mirin. "These claim reviews create a major hardship for psychiatric physicians who often practice in a solo office. These reviews are a significant detriment to quality patient care," said Mirin.

APA also complained that local carriers are instructed to develop LMRPs when CMS finds that certain codes are being used more often in their regions compared with the national average for use of those codes.

"CMS appears to make no effort to determine why the variation exists. For example, carriers may be instructing physicians to use different codes for the same procedure, or a few individual physicians or health care providers are outliers," said Mirin.

To remedy these and other problems, Mirin recommended CMS take the following actions:

- Conduct a systematic review of carrier operations to remove widespread variations in coverage and review practices.
- Work with local and national physician organizations to understand why outliers exist and craft an appropriate solution.
- Conduct analyses of the cost impact a proposed regulation will have before putting it into effect.
- Conduct nationwide physician education workshops to reduce errors on submitted claims.
- Provide clear written guidance on filing claims and explanations of coverage decisions.
- Reduce the adversarial nature of communications with physicians.

Mirin added that psychiatrists' problems with Medicare are not confined to carrier interface. He mentioned the 50 percent discriminatory copay that beneficiaries are required to pay for outpatient psychotherapy services, for example.

Although a 1990 federal budget law requires Medigap insurance to cover the 50 percent copayment, "we continue to hear from psychiatrists who are having difficulty in persuading Medigap insurers that they are in fact liable for coverage of the 50 percent copayment," said Mirin.

He reiterated APA's support for the Medicare Education and Regulatory Fairness Act (MERFA) introduced by Representatives Pat Toomey (R-Pa.) and Shelley Berkley (D-Nev.) and Senators Frank Murkowski (R-Alaska), John Kerry (D-Mass.), and six other senators in March (*Psychiatric News*, April 6). Their bills, HR 868 and S 452, would give physicians more due-process protections when they are alleged to have been overpaid by Medicare and would educate doctors about coding, documentation, and billing requirements, according to Mirin.

HR 868 had 232 cosponsors at press time, including Manzullo, who made it clear at the hearing that he would push for MERFA if CMS doesn't take administrative actions to resolve the problems.

Mirin said, "We are heartened by your committee's discussions with CMS as well as the Ways and Means Health Subcommittee's discussions to find ways that CMS can take administrative actions to alleviate some of the problems mentioned in this testimony. But we continue to believe that legislative action is necessary to ensure that Medicare carriers and CMS address the regulatory morass that discourages physicians from sticking with the Medicare program."

MERFA would also require CMS to issue final rules. Mirin stated, "We are still waiting for the final rule on seclusion and restraint clarifying numerous elements of the 1999 interim rule that applies to acute medical and psychiatric settings."

Mirin's statement on Medicare reform is available on the APA Web site at <www.psych.org/pub_pol_adv/mirintestimony71201.cfm>. ■

Four More States See Value of Parity Laws

Illinois joins 33 other states with full or partial parity laws on the books, while Rhode Island, Kansas, and Delaware amend their existing parity laws to remove certain limitations.

BY CHRISTINE LEHMANN

Illinois became the 34th state last month to enact a parity law.

SB 1341, signed by Illinois Gov. George Ryan (R), requires group health plans to provide coverage for nine "serious mental illnesses" under the same terms and conditions provided for physical illnesses. That means that deductibles, copayments, and coinsurance amounts must be the same for mental illnesses as for other kinds of illnesses.

The nine illnesses are schizophrenia, paranoid and other psychotic disorders, bipolar disorders, major depressive disorders, schizoaffective disorders, pervasive developmental disorders, obsessive-compulsive disorder, depression in childhood and adolescence, and panic disorder.

Beginning next January, group health insurers must provide coverage for 45 days of inpatient treatment and 35 outpatient visits for mental illness annually. Lifetime limits are prohibited under the new law.

The legislation also directs the Department of Insurance to conduct a study of the costs and benefits of the parity law and report back to the legislature by March 2005, the year the law is due to sunset.

Rhode Island Gets Full Parity

Earlier last month, a comprehensive parity bill (S 832), was signed by Rhode Island Gov. Lincoln Almond (R), mandating coverage for mental and substance abuse disorders listed in the most recent *Diagnostic and Statistical Manual (DSM)* or *International Classification of Diseases (ICD)*.

Beginning next January, all health care insurers in Rhode Island must apply the same "terms and conditions" to mental illness and substance abuse as for other illnesses and diseases.

The new law amends the state's previous parity law, which was enacted in 1994. That law applied only to "serious mental illnesses" and restricted inpatient stays to 45 days annually.

Because there are no annual day limits on medical and surgical inpatient stays, there are no such limits for mental illness stays under the new legislation.

Other provisions of the law stipulate that outpatient visits for substance abuse treatment are covered for up to 30 hours annually, community residential treatment for up to 30 days annually, and detoxification for up to five episodes or 30 days, whichever occurs first.

Michael Silver, M.D., the legislative representative for the Rhode Island Psychiatric Society (RIPS), told *Psychiatric News* that a mental health coalition including RIPS, the National Alliance for the Mentally Ill (NAMI)-Rhode Island, and the local chapter of the National Association of Social Workers has been lobbying for full parity for at least two years.

"What provided the impetus this year to change the 1994 parity law was a local newspaper story that ran about six months ago about a girl with anorexia nervosa who was discharged prematurely from a local hospital. The lieutenant governor saw the article and urged the legislature to introduce a new parity bill that added anorexia nervosa to the list of serious mental illnesses. That became S 832, which was introduced in March," said Silver.

However, proponents of full parity offered a competing bill that was accepted by the bill's sponsors as a substitute amendment to S 832 and was passed by the legislature in June, said Silver.

The new law excludes coverage for treatment of mental retardation, learning disorders, communication disorders, motor skills disorders, and disorders classified as "V" codes (defined in *DSM* as "relational problems" and "conditions that may be a focus of clinical attention").

"We had less of a fight this year from the insurance industry than in 1994, because its experience with health insurance premiums showed only a small increase," said Silver.

Other Parity Laws

Kansas enacted a new parity law in May that, starting next January, requires all group health plans that cover mental illness to use the same deductibles, coinsurance, and other limits that apply to physical illnesses, according to the legislation.

A major change from the state's 1986 parity law was removing the discriminatory lifetime dollar cap ($7,500) on outpatient visits. In exchange, parity proponents—including the Kansas Psychiatric Society and NAMI-Kansas—agreed to a limit on the annual number of outpatient psychiatric treatment visits and inpatient psychiatric treatment days of 45 each, according to the July/August *Health Affairs*.

The new law retains the outpatient lifetime cap of $7,500 for alcohol and substance abuse treatment, but provides for 30 days of inpatient coverage, according to the legislation.

Group health plans that cover prescription drugs must also cover psychotropic drugs under the same terms and conditions

see ***Parity Laws*** *on page 28*

Jail Program Helps Inmates Avoid Health Care Gap

Several jails around the country have devised ways to avoid a long-standing problem—how to ensure that released inmates get on the Medicaid rolls and thus become eligible for psychiatric care.

BY LIZ LIPTON

Before 1998 employees at the Corrections Division of the Lane County, Ore., sheriff's office were frustrated because many inmates—including some who were only incarcerated several days—were terminated from the Oregon Health Plan (OHP), the state's Medicaid demonstration project. Employees also had difficulty enrolling inmates in the Medicaid plan, said Richard Sherman, M.S., mental health supervisor for the corrections division.

Sherman explained this situation to administrators of the Oregon Mental Health Division and Oregon Office of Medical Assistance Programs, and after a series of discussions with state officials, convinced them to adopt a policy stating that inmates incarcerated for 14 days or fewer will not be disenrolled from the health plan.

"This is the only state I know of that has such a policy," said Collie Brown, senior director of criminal justice programs at the National Mental Health Association (NMHA). "And as other jurisdictions look to replicate this policy, hopefully they will expand the time frame to more than 14 days."

But this was only part of the efforts by the jail's mental health staff. They also have started an initiative to ensure that inmates in their jail diversion program—all of whom are diagnosed with severe and persistent mental illness—can access their state health plan benefits upon their release.

Here is how the initiative works:

First, these inmates receive help from jail employees in filling out the plan application. Then staff members fax each application to the Senior and Disabled Services (SDS) Office a day or two before the inmate's release. (The office will not accept inmates' applications any earlier.)

Then, in contrast to the time it often takes for governments to process forms, the applications are processed in a day or two. Prior to developing this initiative, inmates had to wait several weeks for their applications to be processed, during which time they were without health care coverage.

Finally, the SDS Office faxes the jail back the inmates' temporary cards, which can be used immediately to access all health plan benefits. A permanent card is sent after the inmate has chosen a managed care organization. Furthermore, in case there are any problems or inmates need help with other issues, the jail staff stays in regular contact with former inmates.

Missing ID?

When asked what happens if an inmate doesn't have ID for the application, Sherman replied, "Inmates don't need to have identification. We identify inmates with their fingerprints. We know better than any other agency who someone is.

"When we fax the application, the SDS Office takes our word for it that the person is who we say he is. In the majority of cases these are not people who are new to the system. They are people who we know from their other visits to the jail and their involvement in the mental health system." However, he noted, "Unless we can positively identify someone, they will not be eligible for our program."

This is particularly impressive because the SDS Office used to require several forms of identification. Because many of their inmates diagnosed with severe and persistent illness didn't have any ID, this was a huge problem.

First, the inmates needed ID to get ID. In addition, many didn't have the money to purchase IDs and were unable to navigate the system to get necessary documents, Sherman said.

Reflecting on the overall effect of all these changes, Sherman said that more inmates have stayed in treatment and have not returned to jail than was the case before the program was implemented.

In contrast, to apply for Medicaid in Rensselaer County, N.Y., released jail inmates need a shelter verification, birth certificate, picture ID, and Social Security card. Most must have a drug and alcohol evaluation, said Michelle Ahearn, forensic mental health discharge planner for the county mental health department. "It's a nightmare. No one will give you a birth certificate without a picture ID, but you can't get picture ID without a birth certificate. . . . It's a catch-22," she said.

Sherman said that the key to developing the Oregon initiative was that "we went to the Senior and Disabled Services office and developed a rapport with the employees. It really does help. We told them about the work we are doing and that it is really important to have inmates on the health plan upon their release, so they can continue with their medication and remain stable. This saves everyone time and money."

Hamden County Experience

When any of the 1,700 inmates residing at Hamden County Correctional Center in Ludlow, Mass., are incarcerated more than 30 days, their MassHealth enrollment is terminated. (In Massachusetts, Medicaid is called MassHealth.)

To counter this, the correctional center's administrators have developed an innovative program to ensure that eligible inmates receive MassHealth benefits upon their release.

"Before we had this program it was a nightmare. You have people in jail, stable, doing better than they ever have done in their lives, and you release them, and they fall on their face, because there was nothing out there to pick them up," said Sandy Gallagher, vice president of forensic services for Behavioral Health Networks. Behavioral Health Networks is a community mental health agency whose forensic division provides services in the jails and courts in Western Massachusetts.

*see **Jail Program** on page 28*

Controversy Continues Over MCO Termination Clauses

Skirmishes continue in the long-running battle between mental health practitioners and managed care over contract conditions.

BY KATE MULLIGAN

On June 29 yet another chapter unfolded in the long-running legal battle between mental health practitioners and managed care companies. ValueOptions Inc., the country's largest privately held managed behavioral health care organization, announced a revision to its provider handbook.

The revision stipulates that ValueOptions will not terminate clinicians from its network for advocating on behalf of their patients, filing complaints against the company, appealing ValueOptions' decisions, or requesting reviews of or challenging termination decisions.

Don Fowls, M.D., chief medical officer of FHC Health Systems (ValueOptions' parent company), said, "No change in ValueOptions' practices occurred nor was any necessary because ValueOptions has always adhered to the above policy. ValueOptions values its relationships with the health care professionals who participate on its provider panels and recognizes clarification of its termination policy as a positive step in further supporting those relationships."

The revision came about after a May hearing in federal district court in follow-up to the lawsuit *Russell M. Holstein, Ph.D., et. al., v. Magellan Behavioral Health Inc., et al.*, in which the plaintiffs challenged ValueOptions' use of a "no cause" termination clause in its provider contracts. The plaintiffs included individual psychiatrists, psychologists, and social workers, as well as regional organizations representing mental health professionals.

According to the transcript of the hearing, Joseph Sahid, attorney for the plaintiffs, claimed that ValueOptions contracts include the clause, "This agreement may be terminated by either party for any reason upon 90 days' written notice to the other."

He added, "They have no other version of this clause, and it appears in every contract that I have examined."

Roman Lifson, attorney for the defendant, replied, "I'm confident that my client is not trying to deceive anybody" and charged that there was no showing that providers had been terminated for any of the prohibited reasons or that plaintiffs had expressed fear of termination.

"Obviously my client is not going to violate the settlement agreement by using the general clause that exists in its contracts," said Lifson.

Judge Lewis Kaplan asked Lifson why ValueOptions insisted on using the clause, "which on its face appears to permit conduct which you agree your client may not lawfully engage in?" He expressed concern that the clause "would effect the perception of the respective strengths of position of your client and the providers. . . ."

The short hearing concluded with an instruction from Judge Kaplan "to work it out" within two weeks. Sahid told *Psychiatric News* that he was discussing the contract issues with representatives of United Behavioral Health, Magellen Health Services, and Foundation Health Services, which also have "no fault" termination clauses in their contracts.

Erin Somers, a spokesperson for Magellen Health Services, said, "Our company is completely in compliance with the terms of the settlement. We do not terminate providers for any of the four prohibited reasons and have received no complaints or claims that we have done so."

Somers added, "However, because our relationships with providers are important, we will be more explicit and, by August 1, will publish a statement in our online provider handbook stating that we will not terminate for the prohibited reasons. Contracts issued after August 15 and hard copies of the handbook published in October will also contain the statement."

Lisa Myers, a spokesperson for Foundation Health Services, said, "We acknowledge the plaintiffs' concerns and are continuing to work with their lawyer on this contract issue. However, the *Holstein* settlement did not include a stipulation prohibiting "no cause" clauses. We have not and will not terminate providers for any of the four reasons mentioned, but we do have a 'no cause' clause in our contract. Among other reasons, that clause is necessary in case we have to change a geographic service area or cannot come to agreement about payment rates."

Spokespersons for ValueOptions and Magellan Health Services also said that they had not dropped the "no cause" clause.

Lawrence B. Lurie, M.D., chair of APA's Committee on Managed Care, said, "Psychiatrists must be able to advocate for their patients. It's very important that contracts do not inhibit us from doing what's best for our patients."

> **"It's very important that contracts do not inhibit us from doing what's best for our patients."**

APA Trustee Norman A. Clemens, M.D., an attendee at a postsettlement meeting between plaintiffs and the managed care companies, said, "The announced change is a welcome first step, but is only one of many steps that managed care companies must take in order to get qualified psychiatrists to work with them. We will be adopting a 'wait and see' attitude and paying particular attention to whether or not the change is applied to everyone."

The history of the hearing dates back to an out-of-court settlement of a lawsuit filed in 1998 by seven clinicians against the nation's largest behavioral health carveout companies (*Psychiatric News*, June 16, 2000). The companies named were Green Spring Health Services, Human Affairs International, Merit Behavioral Care, CMG Health, Options Healthcare, Value Behavioral Health, United Behavioral Health, Foundation Health Services, and MCC Behavioral Care. (After the suit was filed, Merit took over CMG, and Magellan absorbed Green Spring and Merit.)

The suit charged the companies with an illegal conspiracy to restrain trade by agreeing to fix prices and reimbursement levels, which resulted in severe financial harm to the plaintiffs. It also contended that as a class, all patients whose care was affected by decisions made by these companies suffered harm as a result of reduced access to the care their treating clinicians determined they required.

The settlement did not refer to the price- and reimbursement-fixing charges, which all of the firms denied, nor did it require payments from or acknowledgement of wrongdoing by the companies named. The companies did, however, agree that they will not terminate clinicians who advocate on behalf of an insured patient, file a complaint against one of the firms with which they have a contract, appeal a decision by one of the carveout companies, or challenge or ask them for a review of a treatment-termination decision they made. That agreement was the basis for the most recent hearing. ■

Carveout Can't Deny Coverage Months After Treatment, Judge Rules

A judge throws out a suit by Magellan in which it claimed that an independent review panel had no right to overturn its decision to deny coverage for a beneficiary's inpatient psychiatric care.

BY KEN HAUSMAN

A Vermont court has told a major mental health carveout company that taking its time to decide whether to approve a psychiatric patient's inpatient treatment is not an option under state law.

A Superior Court judge in Washington County, Vt., dismissed a case brought by Merit Behavioral Care, now part of Magellan, the country's largest carveout firm, in which the company charged that a review panel had no legal basis on which to overturn a Merit decision to deny coverage to a patient who had already completed inpatient treatment.

Merit, and now Magellan, has a contract with the state to manage the mental health care of state employees who receive their health care insurance through the state. Its agreement with Vermont sends care denials to "an independent panel of mental health professionals."

The case that led to Merit's lawsuit against the state of Vermont involved a patient who was admitted for psychiatric care to the Austen Riggs Center, a private, nonprofit psychiatric hospital in Stockbridge, Mass. The suit also named the hospital as a defendant.

As required by its contract with the state, Merit was promptly notified of the patient's admission to the hospital, and the company then conducted an inquiry of the circumstances of her illness and proposed treatment. In the early phases of the patient's treatment, however, Merit elected to defer a determination of the appropriateness of the patient's care and whether it fell within the scope of its contractual duty to pay for the treatment, according to court documents. It told administrators at Austen Riggs that such a decision was "pending" until an unspecified later date.

After several months had gone by and the patient had been discharged, the managed care company decided that the treatment the hospital provided was not medically necessary or reimbursable under the terms of its contract with the state government.

> **"The legislature quite clearly is reluctant to see mental health care proposals of individual clinicians denied."**

Merit's denial decision was overturned by the independent review panel, which the state legislature established in 1994 "to adjudicate disputed mental health managed care decisions," explained Jonathan Weker, M.D., the Vermont psychiatrist who chairs the review panel.

That panel's determination is what led the company to file its lawsuit calling on the court to reverse the panel's order that Merit was required to pay for the patient's hospital care. Neither Merit nor the state disputed the facts of the case.

Merit did originally authorize a five-day hospitalization, but this ran up against the Riggs Center's minimum 30-day requirement, Magellan spokesperson Erin Somers told *Psychiatric News*. When the five-day authorization expired, and the hospital declined to participate in a concurrent review of the patient's treatment, Merit's options, she said, were to deny authorization for a longer hospitalization or "approve an unlimited stay, which would have been a violation of our contract" with the state government, Somers said.

The solution, she explained, is that "we decided along with Riggs that the [patient] could stay and we would review the treatment at a later date." By "pending" the final review until after discharge, "we were acting in the patient's best interest," Somers said. This post-discharge review and subsequent denial when Merit decided the hospitalization was "not medically appropriate" brought the issue to the review panel, which overturned the denial.

After reviewing Merit's objections, the court ruled against the managed care company and entered a summary judgment on behalf of Vermont and Austen Riggs Center, which terminated Merit's suit.

The court cited a state law governing insurance companies that says reviews of medical care must be concurrent with treatment or conducted before treatment begins. It acknowledged that while managed care companies are not identical to insurance firms, the two are similar enough that the state statute on the obligations of in-

see ***Coverage Denial*** *on page 24*

IMGs: More Than Meets the Eye

BY SHAUNA P. REINBLATT, M.D.

Recently a fellow resident seemed surprised to learn that I am actually a foreign-trained doctor. This was met with equal surprise on my part, as I had never considered myself to be "different" in any way, although I had emigrated from Canada. On further reflection, perhaps I was taken aback as I had denied the differences between training in Canada and the States and focused on the similarities. Maybe I even repressed the fact that, despite my prior family medicine residency in Canada, I had to restart training from my internship year to ensure future U.S. board eligibility in psychiatry.

I suppose I am not an international medical graduate (IMG) by the strictest definition, but I feel this to be an artificial distinction. Although being considered foreign by my fellow resident was not ill intentioned, it did give me pause. I began to question how IMGs are perceived and their increasing role and importance in psychiatry residency programs and the field of psychiatry overall.

Debates concerning IMGs have existed for decades, starting with a climate of relaxed immigration policies in the 1960s, which addressed physician demand at the time. Public policy and attitudes toward foreign-trained physicians have waxed and waned ever since, as concerns regarding physician oversupply emerged. As a result, IMGs may face many obstacles such as barriers to immigration, assiduous application procedures to residencies, and more stringent criteria for licensure to fill medical positions.

There is a broad range of attitudes toward IMGs, which reflects a general sense of ambivalence among physicians. While some doctors may perceive IMGs as coworkers who share the profession, others may view them as competition. Some IMGs themselves are reluctant to be lumped together and labeled as a group, with a concomitant loss of individuality. Rather, they are multifaceted and unique physicians who have simply trained in countries outside the United States.

Endurance to withstand immigration and multiple examinations selects out those more motivated, diligent, and goal oriented from the pool of foreign-trained physicians. Often these doctors have undergone a career change and received additional training in other specialties in their native country, and this brings an added dimension to their patient care. At times they bring additional psychiatric views from their country of origin, which, combined with American training, enriches their vision and conceptualization of cases. Certainly in my opinion, these characteristics serve to help form a well-rounded physician.

Numerically, the AMA 1999 Census of Graduate Medical Trainees showed IMGs to be very significant, with more than 40 percent of psychiatry residents being foreign trained. I was pleasantly surprised to learn (from analyses of the 1996 Survey of Psychiatric Practice) that nearly two-thirds of IMGs in psychiatry are women, which contrasts with many other specialties. This coincides with a similar trend among U.S.-trained psychiatrists and may help further strengthen the voice of women psychiatrists in American psychiatry.

IMGs are also a more varied group than U.S.-trained psychiatrists in terms of race and ethnicity. This information parallels recent national census data showing the United States to be a "melting-pot" society with a trend toward racial and ethnic diversification. Reflecting these changes by a corresponding increase in the ethnic diversity of psychiatry residents would thus have positive effects. Foreign-trained psychiatrists help increase representation of minority groups within psychiatry.

Coming from many diverse backgrounds, IMGs may help bridge cultural and ethnic barriers. Cultural competency, which includes the skills to understand cultural differences between groups and their presentation of mental illness, is of particular relevance to psychiatrists and their patients. Residencies increasingly support the development of such skills, and requirements to do so are evolving. There is no one better to understand patients (and help teach other psychiatrists to do so) than physicians who share similar backgrounds with their patients.

Sensitivity to and familiarity with the ethics of a culture and its attitudes regarding mental health are vital. Patients from groups with greater cultural prejudices about seeking psychiatric treatment might feel more comfortable being treated by someone from a similar background, thereby reducing the occurrence of their being underserved. If it is taboo to shake hands with a member of the opposite sex due to religious reasons, who better to understand than a doctor from a similar culture?

Lastly, speaking the same language greatly facilitates the interview process and increases the detection of subtle details that might otherwise be missed through translation.

While I understand the notion of supply and demand and the anxieties over future

see ***Residents' Forum*** *on page 25*

Dr. Reinblatt is a chief resident (PGY-4) at Hillside Hospital–Long Island Jewish Medical Center in Glen Oaks, N.Y. She is also the MIT representative for the Queens Psychiatric Society and the Assembly's MIT representative for Area 2.

Prisons Partner With University To Improve Psychiatric Care

An innovative partnership between Dartmouth's department of psychiatry and the New Hampshire prison system will benefit the state's inmates and give psychiatry residents essential training.

BY AARON LEVIN

This fall the department of psychiatry at Dartmouth Hitchcock Medical Center in Hanover, N.H., will begin implementing a program to provide psychiatric treatment for inmates throughout the New Hampshire state prison system. Whether or not there are more psychiatric patients in prisons than in mental hospitals, as the conventional wisdom has it, corrections officials across the country worry about increasing numbers of prisoners with diagnosed mental illness in their institutions.

Agreements like Dartmouth's are becoming more common as the overall prison population rises and, with it, the numbers of prisoners identified as mentally ill. Other states have contracted, directly or through managed care intermediaries, with academic centers for overall medical care of prisoners, including psychiatric treatment (see box). However, Dartmouth's contract, valued at $1.3 million a year, may be unusual in that it is between a single department and an entire state prison system.

Dartmouth's contract with the New Hampshire Department of Corrections arose from 12 years of providing psychiatric services at the New Hampshire Hospital in Concord, the state's only public psychiatric hospital. Work in that institution's secure unit for severely mentally ill prisoners led to much interaction with the Department of Corrections, said Peter Silberfarb, M.D., chair of the psychiatry department at Dartmouth.

Now the department will expand its services to New Hampshire's main prison in Concord and three smaller prisons, one of which houses only women. The Concord facility includes the Secure Psychiatric Unit (SPU), which houses not only severely mentally ill prisoners but other involuntarily committed patients as well. Dartmouth will hire a forensic psychiatrist to direct the program and put together a team of psychiatrists, clinical psychologists, social workers, and others.

Program Offers Many Benefits

Silberfarb cited many benefits of the program. "It is the right thing to do clinically, and it could save society a lot of money," he said. According to the U.S. Bureau of Justice Statistics, prisoners with some history of mental health problems serve longer

see ***Prisons*** *on page 29*

The Massachusetts Model

While New Hampshire will provide psychiatric care for its prisoners by contracting directly with Dartmouth's department of psychiatry, Massachusetts has chosen a different path. There are 10 major prisons and 14 smaller units in the Massachusetts system. Out of 10,000 inmates, about 18 percent have open mental health cases, said Kenneth Appelbaum, M.D., director of correctional mental health programs at the University of Massachusetts Medical School in Worcester. Bridgewater State Hospital contains 300 inpatient beds and is used for forensic evaluation.

Beginning in 1992, the state contracted with the medical school for all mental health services as part of an overall agreement for medical services with a private contactor. The contract was awarded to Correctional Medical Systems (CMS) of St. Louis in 1994 and again in 1998. Over time, the psychiatry department has gained a greater degree of functional control over the delivery of psychiatric services, within the terms of the subcontract.

The department of psychiatry provides the same mental health services available in a community mental health center, using multidisciplinary mental health teams at every major prison in the state, said Appelbaum. These teams include a psychiatrist, as well as clinical psychologists, social workers, other licensed clinicians, and psychological rehabilitation professionals and services. Their job begins with the identification and screening of all incoming inmates within seven to 14 days of entry into prison. Those who screen positive for mental illness are then given a comprehensive mental health evaluation.

Prisoners get case management, psychopharmacology, crisis management, and other programming on an outpatient basis (outpatient being a relative term). There are residential treatment units for individuals with serious and persistent mental health disorders, including hospitalization. At present, 12 percent of the prisoners are on psychotropic medications and are being followed by a psychiatrist.

"Staffing levels are often better than in the community," said Appelbaum. "Perhaps 150 patients on medication are looked after by one full-time psychiatrist."

Appelbaum noted that the correctional system benefits from the subcontracting arrangement because the university psychiatry department can help encourage new psychiatrists to work in the corrections system following residency.

Besides benefiting financially from the subcontract, said Appelbaum, the department of psychiatry (part of the state's only public medical school) provides health care to an underserved population and gains opportunities for research and training.

But there are challenges, he said. Practicing psychiatry in prisons is not for everyone. Some people feel uncomfortable, but most are pleasantly surprised. Inmates are often extremely appreciative at receiving good care. Since prisons are in the business of providing security, civilian staff members are not placed in vulnerable positions and may be more secure than working in other settings.

In Montana, State Hospital Opens a New Door

After a century and a quarter, Montana's state psychiatric hospital is still a refuge for the seriously mentally ill, thanks to Montanans' decision to build a brand-new, $20-million building.

BY JOAN AREHART-TREICHEL

Montana State Hospital's new $20 million building has many positive features, including windows that are designed so that abusive substances can't be slipped in through them to patients.

This is the entrance to Montana State Hospital's 124-year-old campus. Originally a health resort built in the 1870s, the hospital was purchased in 1912.

It all started a long time ago, with a mound of dirt spewing out scalding hot water—a "Warm Springs" that the Sioux Indians considered sacred. During the 1870s, a health resort was built near the springs; the outlaw Jesse James reputedly stopped by for a visit. In 1877 a physician and his partner bought the resort and decided to care for mentally ill patients.

In 1912 Montana purchased the resort, and it became the state's sole mental hospital, ultimately named Montana State Hospital at Warm Springs.

As the 20th century marched on, the hospital blossomed into a world all its own. There were hospital buildings connected by an underground passage—a means of getting from one to another during Montana's brutal winters. There were poultry buildings, a dairy, gardens, a greenhouse. There were even two cemeteries since many of the patients who came to the hospital lived there until they died. By the 1950s, some 2,000 patients were being cared for at the hospital.

> **"I think we need to work better with the community, and the community with us."**

As the 1960s and 1970s passed, however, the hospital started reducing its patient population, just as many state psychiatric hospitals throughout the U.S. were doing. The downsizing continued into the 1980s and 1990s. By 2,000 only about 200 patients were being cared for at the hospital at any one time.

And today, near the Warm Springs, which is still disgorging scalding water, many of the former hospital buildings are empty and locked, desolate skeletons of their former selves, no longer meeting safety codes and other standards. In fact, the area of the hospital campus near the springs looks like a ghost town. But wait!

On the other side of the hospital campus, several buildings are still in use. And most astounding of all, a splendid new hospital building, with a price tag of $20 million has risen in their midst. It started operating last fall.

In brief, the 124-year-old hospital will not be closing its doors. To the contrary.

True, the decision to keep the hospital open and to endow it with a brand-new building did not come quickly or easily. It was quite contentious—hotly debated in the state legislature and opposed by some state advocacy organizations. In fact, a lawsuit was filed in federal court claiming that construction of the new building would violate the Americans With Disabilities Act, because the state would have an incentive to keep people in the hospital rather than provide them with community care. The lawsuit, however, was dismissed. Eventually money for the building was appropriated, and it was constructed.

What is the new building like? Let's take a look on a bright summer morning, with swallows whizzing around and snowy

Some States Refuse to Board Hospital-Closure Bandwagon

Even though state mental hospitals have downsized considerably and a number have closed their doors since the 1960s, the state mental hospital as a treatment facility is not about to vanish.

BY JOAN AREHART-TREICHEL

Downsizing has been the name of the game at state mental hospitals since the 1960s, when President John F. Kennedy signed the Community Mental Health Act, and America started the huge process of moving tens of thousands of patients out of mental hospitals and back into the community.

Tatjana Caddell, D.O.: "I think there will always be a need for a place for the severely mentally ill."

For instance, the population of New York state's psychiatric hospitals plummeted from a high of 93,000 in 1955 to some 6,000 today, according to an article in the May 30 *New York Times*.

The downsizing has gotten to the point that even some people working close to the scene get the impression that all state mental hospitals will soon be closing their doors. For instance, as Rick Foster, a licensed practical nurse who has worked for 14 years at Montana State Hospital at Warm Springs, told *Psychiatric News*: "It scares me that hospitals all over the nation are closing."

But are they?

True, some undoubtedly are. For example, when Tatjana Caddell, D.O., left Oklahoma three years ago to become a staff psychiatrist at Montana State Hospital, "They were closing the Eastern State Hospital in Oklahoma," she said. Virginia's governor has proposed closing three of Virginia's 15 state mental hospitals, according to the April 11 "Virginian Pilot" on the Web.

However, a number of other state mental hospitals do not appear to be shutting down, according to Rajir Minhas, M.D., acting medical director of Montana State Hospital. Minhas attended a meeting of the National Association of State Mental Health Program Directors recently, which was also attended by representatives of state psychiatric hospitals from Arkansas, Connecticut, Louisiana, Maine, Minnesota, Texas, Wisconsin, and several other states. None of the conference participants talked about shutting down state hospitals, he said in an interview with *Psychiatric News*.

In fact, a number of state mental hospitals appear to be getting new facilities. A prime example is Montana State Hospital (see accompanying article). "Utah has recently built new facilities on their Utah State Hospital campus," Ed Amberg, administrator of Montana State Hospital, told *Psychiatric News*. "Wyoming is looking at building a new facility on its mental hospital campus. State Hospital North in Idaho recently built a new facility."

According to a January 24 article in New Jersey's largest newspaper, the *Star-Ledger*, a new state-of-the-art psychiatry facility will replace the hulking, asylum-style Greystone Park Psychiatric Hospital in Parsippany. And as Thomas Gray, M.D., a young psychiatrist who left Maryland earlier this year to join the Montana State Hospital staff, said: "As I understand it, there is a recently completed mental hospital on the Eastern Shore of Maryland. I also think Crownsville Mental Hospital in Maryland is planning to build a new hospital." So it doesn't look as though the state mental hospital as a phenomenon is going to vanish any time soon, although as Amberg conceded, "Ten years ago, everybody was wondering whether state mental hospitals would continue to exist."

So what form might state mental hospitals take during this coming decade? "Across the country we are seeing a greater proportion of state hospital patients who are committed [through] the criminal court system," Amberg said. "I think that trend will continue."

"I think there might be a greater proportion of personality disorder patients," Gray predicted, "because the newer medicines are getting patients with schizophrenia out of the hospital," yet medications are having only a limited impact on patients with personality disorders.

Caddell concurred with him: "If things keep going the way they are, we are doing a really good job with the schizophrenia-spectrum patient. What we haven't handled yet are Axis II disorders such as personality disorders. This proportion of the mentally ill population is very difficult to deal with. They are time consuming and labor intensive," she said, "and need a lot of attention and reassurance—things you can't get from medications."

In fact, Caddell anticipates that the state mental hospital as a phenomenon will be around for a long time yet. "Maybe some of the hospitals will be more regional, depending on the population," she said. "But I think there will always be a need for a place for the severely mentally ill."

Gray agreed: "I think there is going to be a role for hospitals like this for the severely and persistently mentally ill."

And Minhas added that he believes "state mental hospitals will always be there. But their role will change, I think, from being long-term institutions to more acute-care ones."

More information about the status of state mental hospitals can be obtained by visiting the Web site of the National Association of State Mental Health Program Directors at <www.nasmhpd.org>. ■

Mount Haggin glistening in the background.

It is a large modern structure in white, aqua, and earth tones, with four pillars fronting the entrance. Once inside, one is struck by the lofty ceilings, the light and airy atmosphere, and the tastefully decorated great room, or rotunda, that forms the heart of the building. Here, a number of patients socialize or visit with family members. Behind the great room is a cafeteria, and four halls fan off from the great hall in the form of an X, leading to four separate hospital units.

> "There are more single bedrooms than there used to be, which helps with snoring patients and other problem patients."

One unit is devoted to older people with Alzheimer's disease or other mental disorders. Besides having single and double bedrooms, the patients have their own television day room, and there is a bay where unit staff work. A number of patients in this unit will eventually be released to their families or to nursing homes.

A second unit, also containing single and double bedrooms, a television day room, and a bay for staff, is reserved for patients needing acute care and rapid stabilization. Some are individuals with schizophrenia who live and work successfully in the community yet need to return to the hospital three or four times a year for medication readjustments or other services. Today, a patient who has just been admitted to the unit insists that she is from the police department, that she is physically, but not mentally ill. She is obviously very distressed and in need of care.

A third unit, similar in layout to the other two, is devoted to mentally ill patients who need more long-term care than the acute unit can provide.

Forensic Unit

And the fourth unit is the forensic psychiatric unit. Here, one walks through two electronic security doors to arrive in a television day room occupied by 15 seriously mentally ill patients who have committed various felonies or have been found not guilty by reason of insanity.

They are sitting in a cluster, watching a psychotherapy video. One young patient, "Ann," gives a tour of her room to Connie Worl, the hospital's public relations and quality improvement director, and to a visitor. The room contains a neatly made bed, bright, artwork, and a mobile that Ann has made. "Do you mind living mostly with men?," Worl asks.

"No, it doesn't bother me," Ann replies.

One of the hospital's older buildings is now being used as the Butte, Mont., city jail.

"These patients are some of the most mentally stabilized in the entire hospital," psychiatric technician Marlys Hurlbert reassures Worl and her visitor. Hurlbert has worked in the unit for some 25 years, ever since she graduated from high school, and appears to feel totally at home with these patients. "A quarter century ago," she said, "patients in this unit were much more violent. I remember one patient throwing her bed against the wall."

The forensic unit also has a special admissions door where the police can bring in persons who have been indicted for crimes and need to be evaluated for mental illness.

The new building also contains an area where patients can receive dental work and other medical care.

Advantages

What difference is the new building making in the lives of the hospital staff? "I can get to meetings on time now because we are all in the same building," said Virginia Hill, M.D., a vivacious woman with lively brown eyes and a winning smile who has served as the hospital's forensic psychiatrist for 15 years. "And since we are now centralized," she added, "we can communicate better with each other."

"It is very helpful for all of us to be under one roof," noted Ed Amberg, a tall, amiable man who has worked in the hospital for 22 years in various capacities and who has been the hospital's administrator since last fall.

"There are more single bedrooms than there used to be, which helps with snoring patients and other problem patients," noted Tatjana Caddell, D.O., who moved from Oklahoma to Montana three years ago and who has worked as a psychiatrist at the hospital since that time.

Another advantage of the new building, Hill pointed out, is that it exposes patients to fresh air. Before the new building, patients were in a building with recycled air, she said, and there were complaints of sick-building syndrome.

Improvements Still Needed

But does the new building still leave certain things to be desired? "Oh, sure," Amberg conceded. "We have an electronic door system that doesn't work quite right, we still have problems with the nurse call system. The new building was designed for an average daily population of 135; today we have 164. That meant we had to hire additional staff that hadn't been budgeted for."

"Although my patients like just about everything about the new building," Hill said, "the one thing they do miss is the large yard they used to have, where they could play horseshoes and run some laps. Now they have just a small yard."

Even with the new building there are still some difficulties in seeing that patients who are discharged from it continue to get the medical help that they need.

For instance, there are a number of facilities in Montana where discharged patients can get care—two 24-hour, supervised group homes on the hospital campus; private, nonprofit community mental health centers located throughout Montana; a public center for the aged, for example. "But I think we need to work better with the community, and the community with us," Caddell said. "Often it seems as if we are fighting. Say, a center doesn't want a particular patient, says they can't handle it, yet we don't want the patient back either. We need some in-between service that will handle patients who don't need a hospital or group home anymore, yet are not quite ready to return to the community. Such a service doesn't exist at this point."

Hill, too, sees the need for greater continuity between the hospital and Montana's community mental health centers. "One reason I think some tinkering is in order," she explained, "is that we are a state entity. The community mental health centers to whom we often refer our patients are private, nonprofit entities. When you have that kind of separate business structure, it is a little harder to move patients back and forth. So I think it would be better if someone were in charge of the whole thing, like it used to be a few years back, when the state owned the hospital and community mental health services and we all worked together."

Even with such shortcomings, of course, the new building means that the 124-year-old hospital will be able to continue to serve the seriously mentally ill in one of America's largest states. The hospital staff, who are deeply committed to, and fiercely protective of, their patients say that they are very happy about that.

Or as Hill put it: "We are so grateful that the citizens of Montana decided to spend money for this more than $20 million project for people who need our help." ■

Virigina Hill, M.D.: "Since we are now centralized, we can communicate better with each other."

Clinical & Research News

Teens Show Significant Improvement After Drug-Abuse Treatment

Treatment programs to help teens kick drugs appear to make a difference, a new study implies.

BY JOAN AREHART-TREICHEL

Although a number of different programs have sprung up in the United States in recent years to help youth with drug problems, little research has been conducted to see whether such programs can make a difference. So Yih-Ing Hser, Ph.D., of the University of California at Los Angeles Drug Abuse Research Center and colleagues decided to launch an investigation.

The results of their study, which appear in the July *Archives of General Psychiatry*, suggest that such programs can make a difference.

They zeroed in on 1,167 adolescents being treated in three types of drug programs—418 in eight residential programs, 292 in nine outpatient drug-free programs, and 457 in six short-term inpatient programs. Altogether the programs represented 23 treatment programs in four cities—Chicago, Minneapolis, Pittsburgh, and Portland, Ore.

The researchers wanted to answer three questions about these subjects: What were their patterns of drug use and mental and behavioral problems before they entered the treatment programs? Did their drug use and mental and behavioral difficulties lessen after treatment? Was the length of their stay in treatment related to their post-treatment outcome?

As far as subjects' status before starting treatment, 73 percent had been abusing drugs to such a degree that they were dependent on them. About 25 percent of the subjects had been multiple-drug users. Some 63 percent had also had a mental or behavioral disorder of some kind, such as a conduct disorder, depressive disorder, attention-deficit/hyperactivity disorder, an overanxious disorder, or panic disorder, and 67 percent of subjects had also engaged in criminal activity, which may or may not have resulted in arrests.

Overall, subjects significantly reduced their drug use in the year after treatment compared with the year before it, the investigators found. For example, weekly or more-frequent marijuana use dropped from 80 percent to 44 percent; heavy drinking, which the researchers defined as five or more drinks in a single sitting a least once a week, declined from 34 percent to 20 percent, and any use of other illicit drugs, including cocaine and hallucinogens, decreased from 48 percent to 42 percent

Subjects also experienced more positive psychological states after treatment than before, and participation in illegal acts decreased from 76 percent in the year before treatment to 53 percent in the year after. These improvements were observed across the three types of treatment programs.

As might be anticipated, longer treatment appeared to lead to more favorable outcomes than shorter treatment did, although treatment time was generally short—three-fourths of subjects received it for less than three months. The results did not reveal the minimum length of treatment necessary to obtain positive results.

The report, "An Evaluation of Drug Treatments for Adolescents in Four U.S. Cities," is available online at <http://archpsyc.ama-assn.org> under the July issue. ■

Annual Meeting Continues To Garner Rave Reviews

Drawing enough people to populate a small town, the 2001 APA annual meeting in New Orleans broke all attendance records and was a smashing success.

APA's 2001 annual meeting in New Orleans was a meeting of firsts. Not only was the general attendance unsurpassed by all previous meetings, but more international members than ever before flocked to the Crescent City, according to a report evaluating the meeting.

The report, which was prepared by Kathleen Debenham, director of APA's Department of Continuing Medical Education, was presented to the Scientific Program Committee at its July meeting in Washington, D.C.

"Ninety-eight percent of respondents to the general evaluation believed the quality of the annual meeting sessions to be excellent," the report pointed out. "Ninety-nine percent of respondents felt that the sessions met their educational objectives."

Total attendance at the meeting was 19,887, which beat the previous record attendance, which was at the 1999 annual meeting in Washington D.C., by more than 1,000 attendees.

According to the report, "The strong presence of national and international participants in New Orleans confirmed APA's annual meeting as the premier international meeting for psychiatrists."

In addition to Canada, which far and away led the international contingent with 1,051 registrants, countries represented by more than 150 registrants included France (385), United Kingdom (294), Spain (276), the Netherlands (193), Italy (308), Argentina (226), Portugal (251), Switzerland (190), Denmark (168), and Germany (193).

The large meeting attracted a large number of media to publicize it—213 reporters and producers from 117 different media organizations registered in APA's press office. Eighteen major print and electronic news media and 24 foreign media busily tracked meeting events.

Once exhibitors, staff, guests, and media representatives were subtracted from the total attendance, registration data show that 15,949 attendees registered to attend the scientific sessions, also the highest number on record.

APA utilized a variety of strategies to expand its monitoring of industry-supported symposia (ISS) to ensure that the material presented in these sessions was balanced and unbiased.

Since 1998 APA has used the ISS Resident Monitor Program for both the annual meeting and the Institute on Psychiatric Services, held in October each year.

Residents in psychiatry attend the ISS and, using guidelines developed by APA's Committee on Commercial Support, monitor the following: balance in each presentation, disclosure of conflict of interest by faculty, use of generic/brand names, disclosure of any discussion of unapproved or investigated uses, and any bias toward the supporting company's products.

This year, the Accreditation Council for Continuing Medical Education (ACCME) invited APA to collaborate in a review of commercially supported CME activities at annual meetings, so resident monitors of the industry-supported sessions answered some additional questions generated by ACCME and by APA. Aggregate results were tabulated and forwarded to the Scientific Program Committee, the Committee on Commercial Support, and the ACCME.

The results of the evaluation of those symposia indicated that APA's oversight measures were effective, since overwhelming majorities of respondents agreed that "multiple viewpoints were presented" in the sessions (95 percent) and that "an unbiased view of the topic was presented" (94 percent).

In addition, 97 percent of respondents thought that the ISS would help them improve the effectiveness of their practices.

For the first time, the same oversight process was utilized by resident monitors in review of 15 non-ISS sessions at the meeting. Debenham noted that "the expanded monitoring program underscores APA's dedication to providing balanced scientific sessions across all formats of the annual meeting."

Approximately 8,200 (52 percent) 2001 annual meeting registrants identified themselves as psychiatrists. Of that number 1,543 were residents. Nonphysician health professionals made up only a small portion of the meeting registrants: 1 percent were psychologists, 2 percent nurses, and less than 1 percent were social workers.

Nearly 80 percent of evaluation respondents reported their primary professional activity as patient care, followed by administration, research, and teaching, at 6 percent each. Respondents also were asked to identify their primary work setting, and the percentage of respondents indicating "solo or group private practice" was 33 percent. Other categories of work settings reported were general hospital, 13 percent; university hospital, 16 percent; state/local facility, 6 percent; CMHC, 7 percent; VA facility, 5 percent; and staff-model HMO, 1 percent.

The meeting participants are also asked to include any changes they would like to see or criticisms on their evaluation form. The participants expressed interest in more sessions on psychotherapy of all types, child psychiatry, and medical updates, for instance.

Complaints were few. Due to the large meeting attendance, many participants commented on overcrowded meeting rooms.

The majority of the respondents, however, responded positively on the evaluation forms. As one member put it, "I liked the theme of 'Mind Meets Brain' very much, and found many formats grappling with this question. This made for a very intellectually satisfying meeting."

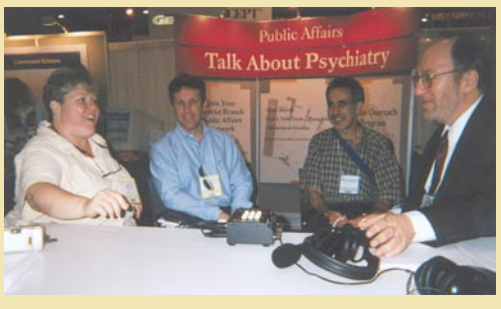
The evaluation of the 2001 annual meeting was based on responses submitted on the General Evaluation Form, which was included with registration materials, distributed on site, and mailed to registrants after the meeting. The evaluation survey could also be completed at 10 computer terminals in the APA Resource Center and at kiosks in the Exhibit Hall.

This year registrants returned 5,237 completed general evaluation surveys.

Next year's meeting will be held May 18 to 23 in Philadelphia. ■

APA MEMBER TAKES TO THE AIR

Michael Blumenfield, M.D. (right), chair of APA's Joint Commission on Public Affairs (JCPA), prepares to begin his live weekly radio program from the APA Annual Meeting Member Resource Center in New Orleans in May. "Talking About Mental Health" airs every Tuesday afternoon from 3 p.m. to 4 p.m. on WVOX-AM from New Rochelle, N.Y., and is rebroadcast Wednesday evenings from 7 p.m. to 8 p.m.



With Blumenfield are his guests from Westchester (N.Y.) Medical Center—Donna Festa, C.S.W., Douglas York, M.P.H., and Neil Zolkind, M.D. The program was part of a JCPA pilot program to test the feasibility of live radio broadcasts from APA's annual meeting under the theme "Talk About Psychiatry."

Simpler APA Dues Structure Will Benefit ECP Members

New and advancing general members will benefit from a simplified dues scale in 2002.

To simplify the dues-billing process, APA members in their first seven years of general membership will pay their 2002 national dues according to a three-step scale.

Members in the first three years of general membership will be charged $180, which is one-third of the full dues rate for general members each year ($540). In years four through six of general membership, members will be charged $355, which is two-thirds of the full rate. In the seventh year of general membership, APA members graduate to the full rate.

"The new dues structure is now simplified and will benefit early career psychiatrists," said Bernard Katz, M.D., chair of the APA Membership Committee. Katz and others, who were part of the Work Group to Study Dues, Value, and Revenue, developed the idea to switch from an eight-tier dues scale to a three-tier dues scale, and APA's Board of Trustees approved the proposal.

Since 1992 APA members have paid their national dues on a more complex, eight-tier dues scale, which eased APA members more gradually into the general membership rate. Dues went up by small increments each year for seven years, and for this reason, some members may have thought that the overall dues rates were increasing, yet the $540 rate for general members and fellows has remained constant since 1996, and the Board recently voted to hold the rate steady for 2002 national dues.

Early career psychiatrists in their first seven years of general membership will actually save money as they graduate up the dues scale to the full general-member rate. With the new three-tier scale, they will pay $140 less than they did on the eight-tier scale over an eight-year period.

Members-in-training, who may be struggling with considerable debt and lower salaries than their colleagues who have more years of practice under their belts, pay just $80 a year.

Similarly, APA life members and life fellows, whose status is a function of their age and number of membership years, pay reduced national dues rates.

To promote consistency and further boost member retention rates, APA is also encouraging district branches and state societies to adopt the graduated dues scale for general members.

Dues statements reflecting the new three-tier system for 2002 will be sent out on October 1. ■

Anonymous Gift To Enhance Library and Archives

An APA member establishes an endowment fund to benefit the APA Library/Archives.

The American Psychiatric Foundation has received an anonymous gift from an APA member to establish an endowment fund to support the development, collection, and preservation of resources about the history of psychiatry in the APA Library/Archives.

Through this gift, the foundation will be able to support the growth of the reference and circulating collection materials on the history of psychiatry; promote the importance of maintaining and expanding the rare books collection; and enhance the development, preservation, and dissemination of oral history resources in psychiatry.

In addition, the fund will provide assistance to scholars undertaking research on the history of psychiatry and provide support for APA's Benjamin Rush Lectureship on the history of psychiatry. Additional contributions to the fund are welcome.

For more information about contributing to this fund or creating your own endowment fund to benefit a program or activity in APA or the foundation, contact Donna Redd by phone at (202) 682-6242 or by e-mail at Dredd@psych.org. ■

Electronic Treatment for Depression Shows Promise

Electronic stimulation of the left vagus nerve to relieve serious, persistent depression has been approved for clinical use in Canada and the European Union. If clinical trials in the U.S. produce positive results, the technique may also receive FDA approval for use in this country.

BY JOAN AREHART-TREICHEL

Suppose a little device were implanted outside the chest cavity under the left arm of a patient suffering from serious, nonrelenting depression. And suppose this little device were electronically stimulated so that it in turn electrically stimulated the left vagus nerve in the patient and thus dramatically relieved or even banished the patient's depression.

This scenario is not science fiction. In fact, it is no longer just a "take" from a medical research setting, but a clinical reality since the technique has been approved for use in both Canada and the European Union.

The approval was announced at the Seventh World Congress of Biological Psychiatry, held in Berlin, Germany, in July. The announcement came from A. John Rush, M.D., a professor of psychiatry at the University of Texas Southwestern Medical Center in Dallas and one of the four psychiatrists who have been testing the technique.

It all started in 1987 when Houston-based Cyberonics was founded to design, develop, and market a unique device for the treatment of epilepsy and possibly other debilitating disorders. It was called a NeuroCybernetic Prosthesis (NCP) System.

The NCP System is an implantable medical device similar to a cardiac pacemaker. During a 30- to 90-minute surgical procedure, usually done on an outpatient basis, a stopwatch-sized generator is placed outside the chest cavity under the left arm, and a nerve-stimulation electrode is attached to the left vagus nerve in the neck.

> **"It would be the first new physical treatment with substantial efficacy since we discovered electroconvulsive therapy in 1938."**

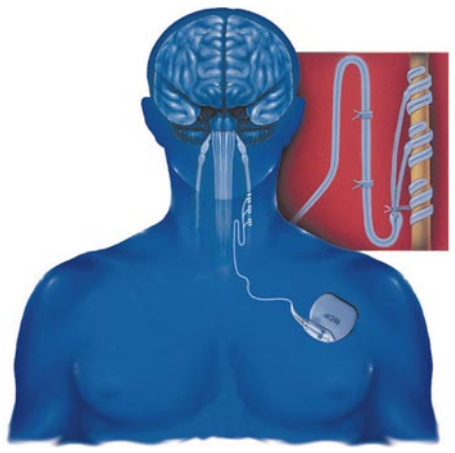
Once the system is in place, a physician can then use an external programmer to turn it on, sending electrical impulses to the vagus nerve. The programmer can also be used to modify the electrical impulses in frequency, intensity, or duration or to turn the impulses off altogether.

The NCP System was first implanted in an epilepsy patient in 1988. It subsequently proved so successful at countering epileptic seizures that in 1997 the U.S. Food and Drug Administration approved it for use as an adjunct therapy for reducing the frequency of seizures in adults and adolescents who are over age 12 and had medically refractory seizures. The system was also approved for such use in Canada, the European Union, Australia, and a number of other countries.

To date, some 12,000 epilepsy patients in 24 countries have had experience with the system. It appears to be essentially safe, although patients have reported negative side effects such as voice alteration, shortness of breath, neck discomfort, and coughing.

A positive side effect, interestingly, has been reported as well—improved mood and cognition. This serendipitous discovery made Cyberonics executives wonder whether the system might also be used to counter depression. So they decided to approach a psychiatrist-medical scientist who they thought would be able to give them an educated opinion and who might be able to conduct a clinical trial to test the system. This was Mark George, M.D., a professor of psychiatry, neurology, and radiology at the Medical University of South Carolina in Charleston and director of the university's Center for Advanced Imaging Research and of its Brain Stimulation Laboratory. George thought the idea had merit, and he agreed to conduct a trial for them.

George then recruited Harold Sackheim, Ph.D., of the New York State Psychiatric Institute to help him with the trial, and



This is a graphic depiction of the NCP System, which has been approved in Canada and the European Union to treat resistant depression. It may also be approved by the U.S. Food and Drug Administration for the same use.

Sackheim in turn recruited Rush, and all three then brought a Baylor College of Medicine psychiatrist on board as well; she was Lauren Marangell, M.D. The "four horses," as Rush described them to *Psychiatric News*, got the trial under way in 1998.

The phase-one trial, which was an open, pilot one, initially included 30 patients who suffered from serious, treatment-resistant depression and who had not been helped by therapies such as antidepressants or even electroconvulsive therapy. A NCP System was implanted into each of the patients, followed by a two-week recovery period with no electrical stimulation of the device. The system in each patient was then electrically stimulated for a 10-week period. Each patient was assessed for depression before, during, and after electrical stimulation.

By the end of 1999, it appeared that the system was indeed capable of exerting an antidepressant effect, at least in certain treatment-resistant patients. Forty percent of the 30 patients studied experienced a lessening of depression following stimulation with the system, the investigators reported in the December 1999 online edition of *Biological Psychiatry* (*Psychiatric News*, January 21, 2000).

After that, the trial was expanded to include 30 more patients, and all 60 of the patients were followed for two years.

Some 30 percent of the 60 patients experienced a substantial lessening of their depression after stimulation; half of this 30 percent had their depression lift altogether, Rush reported at the Berlin congress.

It was on the basis of these results, Rush told *Psychiatric News*, that the NPS System has been approved as a depression treatment in Canada and the European Union.

A double-blind, randomized, placebo-controlled trial to test the technique in persons with treatment-resistant depression in the U.S. is now under way. George, Sackheim, Rush, and Marangell designed it in consultation with Cyberonics and the U.S. Food and Drug Administration. All subjects in this trial will get the implanted device, but only half will get electrical stimulation turned on in the beginning; the other half will get stimulation turned on 12 weeks later. Rush described this as a "delayed treatment control." The idea is to see whether the individuals who do not get stimulation during the first few weeks will do as well as or more poorly than those persons who get stimulation from the start.

If this trial produces positive results, Rush said that he believes that the FDA will approve the system for the treatment of treatment-resistant depression.

And if the method were to receive FDA

see ***Depression*** *on page 29*

Reduced Smell Activity May Point To Schizophrenia Predisposition

Impaired olfaction may be a sign of genetic vulnerability to schizophrenia in persons who come from families with familial schizophrenia, a new study suggests.

BY JOAN AREHART-TREICHEL

Several years ago, Lili Kopala, M.D., a psychiatrist with Dalhousie University in Halifax, Nova Scotia, Canada, and her colleagues examined smell acuity in identical twins discordant for schizophrenia. The twins with schizophrenia had considerable olfaction impairment compared with healthy controls, but the twins without schizophrenia had some impairment as well. The unaffected twins' performance fell midway between that of the affected twins and that of the healthy controls.

This finding made Kopala and her coworkers wonder whether smell impairment might indicate a genetic susceptibility to schizophrenia in persons coming from families with a genetic predisposition to the disease. So they decided to test their hypothesis in another study.

The results, reported in the August *American Journal of Psychiatry*, confirm their hypothesis, Kopala and her colleagues believe.

Kopala and her coworkers gave a smell identification test to three groups of subjects younger than age 65. The first group consisted of 19 individuals with schizophrenia who came from families that had had various members with schizophrenia throughout the generations. In other words, it was clear that a strong genetic predisposition to schizophrenia was present in these families.

The second group consisted of 27 persons who also came from these families but who did not have schizophrenia. These individuals presumably had some genetic predisposition to schizophrenia as well, but had not developed schizophrenia.

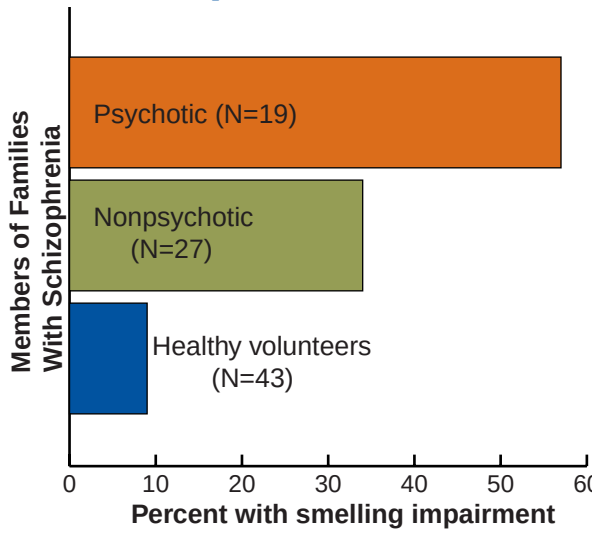
A third group consisted of 43 healthy volunteers who were matched for age and gender to each schizophrenia and nonschizophrenia subject; an adequate match for three subjects could not be found.

The researchers then compared olfactory test results among the three groups. As they expected, subjects with schizophrenia performed worst on the test, healthy controls best, and subjects without schizophrenia but presumably with some genetic vulnerability to the disease in-between. Specifically, 58 percent of schizophrenia patients, 34 percent of nonschizophrenia subjects, and nine percent of healthy controls performed in the impaired range (see chart).

Thus, "impaired olfactory deficits may aggregate in families with schizophrenia and may be indicative of a genetic predisposition to psychosis," Kopala and her colleagues conclude.

The report, "Impaired Olfactory Identification in Relatives of Patients with Familial Schizophrenia," is posted on the journal's Web site at <ajp.psychiatryonline.org> under the August issue. ■

Sniffing Out a Risk For Schizophrenia



Fifty-eight percent of patients with schizophrenia, 34 percent of nonschizophrenia subjects from families with schizophrenia, and 9 percent of healthy controls had senses of smell in the impaired range. "Impaired" was defined as a score on the University of Pennsylvania Smell Identification Test of less than 34 of 40 for men and less than 35 of 40 for women.

Source: Lili Kopala, M.D., et al., Dalhousie University, Halifax, Nova Scotia

Psychiatrist Takes Helm of National Disability Program

Burton Reifler, M.D., M.P.H., takes on the goal of expanding the Faith in Action program with help from one of the nation's renowned philanthropy organizations.

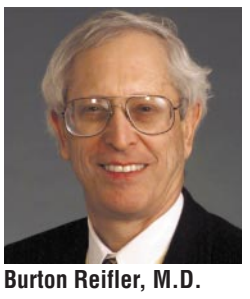
An APA member is at the helm of the Robert Wood Johnson Foundation's (RWJ) signature program to provide support services to people with chronic disabilities.

Burton Reifler, M.D., M.P.H., took over as national program director of the Faith in Action (FIA) program at the beginning of this year, and in May he stepped down as chair of the department of psychiatry and behavioral medicine at Wake Forest School of Medicine in Winston-Salem, N.C., to devote his time and energy to FIA full time.

FIA is a national program consisting of local volunteers of many faiths who work together to care for elderly, chronically ill, or disabled people. The program was established in 1983.

In March the RWJ Foundation granted $100 million to the program—its largest monetary commitment ever—to develop 2,000 new FIA sites in the next seven years.

The RWJ Foundation is a large philanthropy organization dedicated exclusively to health care issues. It was established in 1972 and is based in Princeton, N.J.


Burton Reifler, M.D.

"I think this is a tremendously exciting opportunity to create something that hasn't previously existed," said Reifler. "The idea is to help people with a range of disabilities, including but not limited to mental illness, to function independently in the community."

Volunteers involved in FIA provide simple support services for people in their community, according to Reifler. Some examples are taking someone to the doctor, shopping for those who can't leave home, or doing minor home repairs.

Reifler noted that volunteers who want to help build homes for people or provide disaster relief know which organization to join. "But if you want to provide support services for someone in your neighborhood, you wouldn't know whom to call," he said, a situation he hopes to change.

"My goal is that by the end of seven years, Faith in Action will be a household name and that people motivated to provide that type of volunteer service will know to call their local Faith in Action program."

More information on the Faith in Action program can be found at <www.fiavolunteers.org>. ■

Davis Joins Roster of Psychiatrist Deans

An APA member involved in academic leadership and research became dean of the Michigan State University College of Human Medicine in May.

Glenn Davis, M.D., brings a great deal of experience to his new position. Most recently, he was corporate vice president of academic affairs at the Henry Ford Health System in Detroit and associate dean at Case Western Reserve University School of Medicine.

Before coming to Henry Ford, Davis was a professor of psychiatry at Case Western Reserve and chief of staff at the Cleveland Veterans Administration Medical Center.

Davis serves on the American Board of Psychiatry and Neurology Inc. as secretary on the board of directors and was president of that organization in 2000. He is also a member of the American Board of Family Practice and the American Board of Medical Specialties.

As an expert on aging, Davis served as principal investigator for the Resource Center for Minority Aging Research and completed a fellowship at Duke University's Center for the Study of Aging and Development. Established in 1997, it is a collaboration of the National Institute on Aging and the National Institute of Nursing Research, which jointly funded six resource centers for minority aging research.

Davis joins a group of nine other psychiatrists who are currently deans of medical schools in the U.S.: Larry Faulkner, M.D., University of South Carolina; Eugene Feigelson, M.D., State University of New York, Downstate Medical Center; Ronald Franks, M.D., East Tennessee State University; Carl Getto, M.D., Southern Illinois University School of Medicine; Jeffrey Houpt, M.D., University of North Carolina at Chapel Hill; Edward Hundert, M.D., University of Rochester School of Medicine and Dentistry; Darrell Kirch, M.D., Pennsylvania State University; Aaron Lazare, M.D., University of Massachusetts, Worcester; Ralph O'Connell, M.D., New York Medical College. ■

Career Development Sessions For ECPs to be Held at Institute

The newest members of the psychiatric profession are invited to attend a session that will help ease the transition from residency to full-fledged psychiatrist.

BY TARA McLOUGHLIN

To address the career development needs of early career psychiatrists (ECPs), APA is featuring four special leadership sessions at the Institute on Psychiatric Services, which is being held October 10 to 14 in Orlando, Fla. Topics include transitioning from resident to ECP, ECP leadership, career development for international medical graduates (IMGs), and grass-roots advocacy.

"The Other Side of the Mountain: From Residency to Reality" will be the topic of Friday morning's workshop, led by Steve Goldfinger, M.D., Deborah Hales, M.D., and Ronald Albucher, M.D. While trainees learn the basics of clinical psychiatry, many programs address only peripherally, or not at all, how to translate this training into practice. This interactive discussion between ECPs and senior professionals will explore how training programs have and have not met young professionals' needs and how young doctors can best acquire the skills to prepare for the challenges in their first few years out of residency.

Learning how to excel as a leader is another crucial skill for ECPs. During the afternoon session on Friday, Edward Simmer, M.D., Satya Chandragiri, M.D., Warren Ng, M.D., and Jill Williams, M.D., will draw on their experiences as leaders in their field and as ECP leaders in the APIRE/Janssen Public Policy Program. The participants will discuss their own exemplary programs, as well as the reasons they chose a career in public psychiatry. Special interests of the presenters include military psychiatry, suicide prevention, HIV/AIDS, chronic mental illness, and comorbid mental illness and substance abuse.

Saturday morning's session, led by Renato Alarçon, M.D., Norma Panahon, M.D., Nyapati Rao, M.D., and Gabrielle Beaubrun, M.D., will serve to identify and discuss topics of interest to IMGs. Issues to be discussed will include discrimination, acculturation of IMGs, cultural competency training, bureaucratic barriers to success, and qualification through tests that are as controversial as they are complicated. Said Alarçon, "The panelists hope to foster some interesting dialogue with the audience on these and other topics. We hope that some specific recommendations emerge out of this event."

The final session will focus on advocacy and lobbying skills for psychiatrists. It will be led by APA Division of Government Relations Director Jay Cutler, J.D., and staff Heather Whyte, as well as Ronald Shellow, M.D. They will teach participants how to do constituent grass-roots advocacy easily and effectively. As Rep. Ted Strickland (D-Ohio) recently told Ohio Psychiatric Association members, "Physicians are still greatly respected by legislators. . .and have a high credibility and err in underestimating the impact they can have." Audience members will learn to educate decision makers on public health policy matters and which will be immediately helpful to those in their early careers," he said.

Participation in each workshop is limited to the first 35 attendees. More information on the sessions is available by contacting Tara McLoughlin by phone at (202) 682-6171 or by e-mail at tara@psych.org. ■

Photo: Orlando/Orange County Convention & Visitors Bureau Inc.

Journey to Atlantis is just one of the thrilling roller-coaster rides at SeaWorld in Orlando. SeaWorld is said to be the world's most popular marine adventure park.

Tara McLoughlin is director of APA's Office of Career Development and Women's Programs.

apa institute

Lectures Address Issues Critical to Psychiatrists and Their Patients

Those attending APA's fall institute will hear from leaders in psychiatry in the clinical, administrative, academic, and research arenas.

BY HARVEY BLUESTONE, M.D.

An outstanding and diverse group of lecturers at this year's Institute on Psychiatric Services will address clinical, community, forensic, and other cutting-edge issues confronting psychiatrists at the turn of the millennium.

The lectures alone are well worth the price of admission to the institute, which will be held in Orlando from October 10 to 14.

The 25 scheduled lecturers will cover a broad range of topics from specific clinical approaches to broad public policy considerations. Issues affecting children are prominently featured.

The Scientific Program Committee is pleased that three APA Award–winning lectures will be given at the institute: The George Tarjan Award lecture by Busharat Ahmad, M.D., the Patient Advocacy Award lecture by Professor Latanya Sweeney, Ph.D., and the Alexandra Symonds Award lecture by Ann Ruth Turkel, M.D.

You will have the opportunity to hear from APA leaders wearing their clinical hats. APA President Richard Harding, M.D., will address attendees at the Opening Session. Vice President Marcia Kraft Goin, M.D., Ph.D., will speak on treating patients with borderline personality disorder: struggles, troubles, and triumphs; former President Harold Eist, M.D., on children and violence, clinical aspects; Treasurer Carol Bernstein, M.D., on teaching and doing psychotherapy; Assembly Speaker Nada Stotland, M.D., M.P.A., on better care for women in the public sector; and Speaker-elect Albert Gaw, M.D., on "old wine in new bottles," a Kleinman's cultural paradigm for understanding psychotherapy.

Photo: Walt Disney Company

A visit to the Magic Kingdom at Disney World is enjoyable at any age.

Chairs of academic departments are well represented among the lecturers. Sara Huertas-Goldman, M.D., Ph.D., of the University of Puerto Rico will speak on health systems reforms, mental health care, and the case of Puerto Rico and its relevance for mental health care in the U.S. The chair of my academic department at the Albert Einstein College of Medicine, T. Byram Karasu, M.D., will speak about the psychotherapist as a healer.

Jacqueline Feldman, M.D., president of the American Association of Community Psychiatrists, will speak on "Green Eggs and Ham": developing a passion for public psychiatry (my candidate for the most intriguing lecture title). We will also hear from two private practitioners, George L. Warren, M.D., and Walter Griffith Jr., M.D., on becoming a business expert and running your private practice.

We will also have the opportunity to hear from Regina Bussing, M.D., on barriers to treatment for ADHD; Ana E. Campo, M.D., on enhancing medical recruitment into psychiatric centers; Alan D. Felix, M.D., on the critical time for prevention of homelessness: a review of 10 years of clinical research findings; Harriet P. Lefley, Ph.D., on family education in schizophrenia; Kenneth Minkoff, M.D., on developing integrated care systems for co-occurring psychiatric and substance abuse programs; Bonnie Saks, M.D., on biochemical mechanisms of sexual response; Andres Pumariega, M.D., on systems of care for children's mental health: failures and opportunities; and Wesley E. Sowers, M.D., on forging collaboration—obstacles, opportunities, and innovations.

Margery Sved, M.D., will tell us about the psychiatrist as a foster parent; Harold Telson, M.D., about competence to reside in the community; and Clifton R. Tennison, M.D., on humility in psychiatric leadership (what a refreshing thought!). The final lecture will be given by Thomas G. Gutheil, M.D., on boundary issues in clinical practice. It will be well worth staying to the end of the meeting to hear him.

The lecturers have been scheduled in a way to enable an avid attendee to hear almost all of them. If you have not already registered for the meeting, now is the time to do so (see box above). ■

Dr. Bluestone is chair of the Scientific Program Committee of the 2001 Institute on Psychiatric Services.

Register Now!

There are three easy ways to register for APA's Institute on Psychiatric Services:

- Visit APA's Web site at <www.psych.org>.
- Refer to the special insert on the institute in the June 15 issue of *Psychiatric News* .
- Request a preliminary program from the APA Answer Center at (888) 35-PSYCH. The program contains hotel information and registration forms.

Save on fees by registering before September 10.

Find Your Voice in APA

The APA Special Caucus Program Was Designed for You

The APA Special Caucus Program was developed by members to give colleagues an opportunity to come together, share information, discuss concerns, and identify strategies to address challenges in their practice settings. Six caucuses report to APA's Council on Psychiatric Services—for psychiatrists who work in state hospitals, VA facilities, rural areas, and correctional facilities and psychiatrists who treat patients with mental retardation and developmental disabilities and those with eating disorders. The caucus for Psychiatrists Treating Patients Covered by Managed Care reports to the Council on Healthcare Systems and Financing.

All seven caucuses will meet during APA's Institute on Psychiatric Services in Orlando. Psychiatrists do not have to be registered for a caucus to attend a caucus meeting; however, they must be an APA member to join a caucus.

All meetings will be held at the Renaissance Orlando Resort.

For more information on the State Hospital, VA, Rural, Corrections, Eating Disorders or MR/DD caucuses, contact Chris Druhan at (202) 682-6092. For more information on the caucus for Psychiatrists Treating Patients Covered by Managed Care, contact Karen Sanders at (202) 682-6108.

Friday, October 12

8:30 a.m.-11:30 a.m.
State Hospital Psychiatrists Caucus
Board Room, Second Floor

2 p.m.-5 p.m.
VA Psychiatrists Caucus
Japanero Room, Second Floor

Saturday, October 13

8:30 a.m.-11:30 a.m.
Rural Psychiatrists Caucus
Board Room, Second Floor

10 a.m.-11:30 a.m.
Caucus for Psychiatrists Treating Persons with Eating Disorders
Opah Room, Second Floor

1:30 p.m.-3:00 p.m.
Psychiatrists Treating Patients Covered by Managed Care
Anemone Room, Second Floor

2 p.m.-5 p.m.
Caucus for Psychiatrists Treating Mental Retardation/Developmental Disabilities
Board Room, Second Floor

Caucus of Psychiatrists Practicing in Criminal Justice Settings
Hinalea Room, Second Floor

Why Members Attend APA's 'Hidden Jewel'

APA's Institute on Psychiatric Services is one of APA's best-kept secrets—but it shouldn't be. Here are some reasons why APA members find this meeting beneficial.

Psychiatric News asked several psychiatrists why they attend APA's fall Institute on Psychiatric Services, being held October 10 to 14 in Orlando, Fla.

"I attend most IPS meetings for the focus on the chronic patient and community-based systems of care, which has always been my interest. . . . No other meeting provides so much content and networking opportunities."

David Cutler, M.D.
Director, Public Psychiatry Training Program, University of Oregon Health Sciences Center, Portland, Ore.

"As a former mental health administrator, and strong believer in advocacy for the public sector and for interdisciplinary collaboration, I find the institute both informative and restorative."

Nada Stotland, M.D.
Speaker, APA Assembly

The Institute on Psychiatric Services "offers a well-researched smorgasbord for psychiatrists who deal with chronic and persistent mental illness. . . . An opportunity to learn in a more intimate format."

Elizabeth Galton, M.D.
Private practitioner in Santa Monica, Calif., and Assembly representative from the Southern California Psychiatric Society

"Simply the most enjoyable, useful, and relevant national psychiatric meeting—APA's hidden jewel—cozy, accessible, far more interactive and far more focused on the clinical and system issues that are the core of my identify as a psychiatrist."

Stephen M. Goldfinger, M.D.
Professor and Vice Chair, Department of Psychiatry, S.U.N.Y Downstate Medical Center, Brooklyn, N.Y.

"I attend to learn about cutting-edge programs and treatments that are expanding access and improving quality of care for my patients. The pace allows for more dialogue with colleagues who are frontline pioneers."

Richard Harding, M.D.
APA President ■

apa institute

APA/Bristol-Myers Squibb Fellows To Serve as Institute Faculty

The APA Bristol-Myers Squibb Fellows are new psychiatrists interested in public psychiatry.

BY BEATRICE EDNER

A highlight of every Institute on Psychiatric Services is a series of sessions featuring APA/Bristol-Myers Squibb Fellows as faculty. These third- and fourth-year residents were selected for the fellowship based on their record of academic and professional achievement and their commitment to the field of public psychiatry. Since the fellowship's founding, approximately 250 APA/Bristol-Myers Squibb Fellows have participated in the institute and presented highly acclaimed and well-attended workshops.

This year's institute features the following sessions to be presented by 2000-02 APA/Bristol-Myers Squibb Fellows:

- Catching the Bus: School-Based Primary Prevention and Mental Health
- What Is the Patient Saying? The Psychiatric Interview Through an Interpreter
- How Much Does It Cost? An Ethical Approach to the Pharmaceutical Industry
- The History of Mental Health Professionals in the Juvenile Justice System
- Self-Destructiveness: Implications for HIV Disease

The 2000-02 fellows are (all M.D.s) Marc E. Dalton (Medical University of South Carolina), Daralynn Deardorff, (University of Texas Southwestern Medical Center), Esther J. Dechant (Harvard Medical School, Cambridge Hospital), Daniel P. Dickstein (Brown University, Rhode Island Hospital); Nichole D. Grier (University of North Carolina School of Medicine), Kamlyn R. Haynes (University of Massachusetts), Priyamvada Narayanan (New York University School of Medicine), Steven B. Rudin (Columbia University College of Physicians and Surgeons), Craig A. Stuck (University of South Carolina, William S. Hall Psychiatric Institute), and Pamela E. Swedlow (University of California-San Francisco, Langley Porter Psychiatric Institute).

In addition to the 10 fellows serving as faculty, the recently selected 2001-03 APA/Bristol-Myers Squibb Fellows will attend the institute. They are (all M.D.s) Alison M. Barnes (University of Maryland/Sheppard Pratt Health System), Hagit Bat-Avi (Beth Israel Medical Center), Jaime M. Benitez (Bronx-Lebanon Hospital Center Albert Einstein College), Mathieu Bermingham (University of Massachusetts Medical School), Matthew E. Bernstein (Harvard Medical School-McLean Hospital), Jennifer K. Coffman (Harvard Longwood), Melva I. Green (Johns Hopkins), Raymond J. Kotwicki (Emory University School of Medicine), Eric Levander (Harbor/UCLA Medical Center), and Susan A. Turner (Columbia University College of Physicians and Surgeons).

Both fellowship classes will participate in a number of activities designed to augment the institute's program and provide opportunities to become acquainted with the leaders in the field. Additionally, they will join other residents in sessions the program committee has arranged specifically for resident attendees.

The APA/Bristol-Myers Squibb Fellowship is funded through a generous grant to APA by Bristol-Myers Squibb Company. ■

legal news

Coverage Denial

continued from page 10

surance companies to their beneficiaries should apply in this case.

Superior Court Judge Matthew Katz cited a previous ruling from the same court that "simple fairness requires" that an insurance company "should point out any defects" in a claim it is reviewing if that review could result in a denial of payment. Quoting that decision, Katz ruled that "there was a statutory duty on the part of Merit as review agent to speak—it is the duty to make its decision prospective or concurrent with the treatment" for which it is being asked to pay.

By failing to make that decision until months after treatment had commenced, Merit "waived its objections to the request for coverage," the ruling states.

The judge also examined the language of the applicable state law and the legislature's intent in passing it. While the wording does emphasize the need for cost-effectiveness in insurance review decisions, he maintained that "the legislature quite clearly is reluctant to see mental health care proposals of individual clinicians denied."

Magellan has filed a request for the judge to reconsider his decision, but by press time had not received a response.

[*Merit Behavioral Care v. State of Vermont, et al.*, Superior Court for Washington County, Docket No. 713-99 WnCiv] ■

viewpoints

AMA Wrong on Capital Punishment

BY ABRAHAM L. HALPERN, M.D.

At its annual meeting in June the American Medical Association (AMA) rejected a resolution submitted by the Medical Society of the State of New York calling for a moratorium on capital punishment in the United States. (The resolution followed to the letter the one adopted last year by APA.)

Instead, on the recommendation of the Reference Committee on Constitution and Bylaws, the AMA House of Delegates passed the following resolution: "Resolved, that our American Medical Association does not take a position on capital punishment, and be it further resolved that our American Medical Association urges appropriate legislative and legal authorities to continue to implement changes in the system of administration of capital punishment, if used at all, and to promote its fair and impartial administration in accordance with basic requirements of due process."

The Reference Committee alluded to "the AMA's long-standing tradition to remain neutral on matters that are considered to be nonmedical but issues of society at large and that are highly divisive, such as capital punishment."

At the same time, it strongly endorsed the AMA's policy position, in accord with its Code of Medical Ethics, "that physicians, as professionals who are dedicated to the preservation of life in the face of disease and illness and to the overall health and welfare of patients, cannot simply disregard the public health implications of wrongly convicting or executing innocent individuals," and that physician participation in executions is prohibited.

"Participation," according to the AMA, includes not only the injection of a lethal substance, but also the prescribing or administering of tranquilizers and other psychotropic agents and medications that are part of the execution procedure, monitoring vital signs on site or remotely (including monitoring electrocardiograms), attending or observing an execution as a physician, and, in fact, even pronouncing death. The fact is that physicians do participate in one way or another, and these ethical violations have never resulted in disciplinary action by medical ethics committees. The problem is that many American doctors feel under pressure from state and federal laws and politicians to break their medical ethical commitments, and they feel a strong conflicting duty to their country's laws. Few physicians are strong enough to participate in civil disobedience if that is what it would take to ensure that doctors no longer participate in the killing of people.

The AMA thus has failed to recognize that its high-sounding words constitute mere lip service and that nothing less than an immediate moratorium on, and eventual abolition of, capital punishment can end the unethical participation by physicians in executions. ■

Dr. Halpern is a forensic psychiatrist in Maroneck, N.Y., and a member of the APA Committee on Misuse and Abuse of Psychiatry and Psychiatrists.

Bill of Rights

continued from page 1

that it would preempt stronger state protection laws and make it impossible for patients to win malpractice awards in state courts for personal injury.

Ganske cited an analysis by George Washington University health law professors stating that the amendment meant that state malpractice laws would not apply to any health treatment decisions that are "wanton, negligent, reckless, or willful," according to the August 3 *Congressional Daily Monitor*.

Norwood's congressional allies and other groups that had supported HR 2563 as introduced in the House in July were surprised that he struck a compromise deal with the president.

Norwood explained his sudden shift from advocating for a stronger patients' bill of rights to agreeing to one with weaker liability measures by saying that he was guided by "political reality," according to the August 3 *Congressional Daily Monitor*.

Bush had repeatedly threatened to veto the House bill as introduced, complaining that it would encourage "frivolous lawsuits" and drive up health insurance costs, and could lead employers to drop health care coverage.

When Norwood announced the amendment earlier this month, he said that without Bush's signature, patients would have no new protections against their insurers, according to the August 3 *Congressional Daily Monitor*.

Norwood's compromise culminated a six-year battle to get a patients' bill of rights enacted into law. Norwood, who is a dentist, championed a comprehensive bill in 1999 that passed the House by a large majority but it was never reconciled with the more restrictive Senate version.

At press time Jay Cutler, J.D., director of APA's Division of Government Relations, told *Psychiatric News* that APA was supporting the Senate bill and "looking to the conference committee to come up with the most comprehensive patient-protection bill."

The text of HR 2563 can be accessed on the Web at <http://thomas.loc.gov/> by entering "HR 2563" in the "Bill Number" search box. The text of S 1052 can be accessed at the same site by entering "S 1052" in the "Bill Number" search box. ■

How Do the Two Bills Differ?

When the House and Senate conferees meet next month to work out the differences between their respective Patients' Bill of Rights, these are some of the issues they'll be addressing:

	Senate	House
What the law covers	The bill covers all Americans in private or employer-sponsored health plans and people covered under Medicare, Medicaid, and other federal health plans.	All Americans in private or employer-sponsored health plans.
Where health plans may be sued	Patients may sue health plans over medical care in state court. Cases involving administrative disputes that result in injury or death must be filed in federal court. Patients must first complete an external appeals process, unless the delay would cause imminent harm or death	Patients may sue health plans over care in state court under new federal standards that would spell out damage awards, standards of proof, and other terms. Patients must first complete an outside appeals process. If they lose, they can still sue, but they face a higher legal standard of proof.
Damage awards	In state courts, patients can collect whatever state law allows. In federal court, patients may collect unlimited economic and pain and suffering damages and civil penalties up to $5 million if the plan acted in bad faith.	In either state or federal court, patients can collect up to $1.5 million in pain and suffering damages. They also can collect up to $1.5 million in punitive damages when a health plan refuses to provide care after being ordered to do so by an external appeals panel. States with higher damage awards would be pre-empted by the new federal law.
Employer liability	Employers can be sued in state court only if they participated directly in making the health care decisions. Employers would be exempt from being sued over administrative disputes in federal court if their health plans are self-insured or self-administered	Same as Senate bill, but the bill requires lawsuits against employers that self-insure or self-administer health plans to be filed in federal court.
New health care guarantees	The bill guarantees direct access to pediatricians and obstetrician-gynecologists, choice of doctors with higher copayments, paid emergency room care, medically necessary prescription drugs, and paid routine medical costs for patients participating in federally approved or funded clinical trials.	Same as Senate bill.
Tax provisions	None	The bill allows permanent, unlimited access to medical savings accounts. It also allows small employers to band together and buy coverage through professional or trade groups.

residents' forum

continued from page 12

physician oversupply, I believe that training more IMGs would actually benefit our field. With the current immigration climate, many foreign-trained doctors must return to their countries of origin after receiving their training and having provided service in their teaching hospitals. Those who do remain in the United States seem to work in different settings. Psychiatrist IMGs who stay in the United States after residency tend to focus their practice in particular areas, such as in public psychiatry, groups with limited access to care, and the chronically mentally ill. They tend to treat minorities and underserved populations, sometimes in remote geographical areas that may place added burdens on them but enable them to remain in the country.

There have been arguments to reduce the growth of the physician supply by decreasing the numbers of IMGs. This would have a negative impact on mental health care, particularly for poor, underserved patients. Recently nonmedical practitioners had cited a reported paucity of psychiatric services in underserved areas as supporting their attempt to extend their scope of practice to include prescribing medications. Thus, ensuring the availability of psychiatrists might actually protect our specialty and safeguard the quality of mental health care.

I can't help but think back to so many of the historical figures in psychiatry and how they received their training in other countries. How different would things be if they were working in America today? I believe that enlarging the IMG portion of the psychiatric workforce would greatly benefit the future of our specialty in many ways, but especially by enabling us to maintain accessibility of psychiatric care. As I reflect on my personal situation as a Canadian-trained doctor, I realize that although I do spell some words a little differently and had to use the spell-checker several times while writing this piece, the language of medicine should be more universal than that. ■

Child Psychiatry

The April 20 issue carried an article on the great need for child psychiatrists. I am a healthy, vigorous child psychiatrist, well trained in Boston. One of the reasons I retired from practice in March 1999 was because I was unable to acquire sufficient patients to maintain a private practice. Prior to the reign of managed care, this was not the case. Since the 1980s, however, the ability of families to afford private treatment for their children has diminished to the point of nonexistence. Remember, most young children need to be seen more than once a week, and one or both parents also need be seen at least occasionally. This certainly puts most families beyond the range of affordability without the previously existing aid of insurance coverage.

So what is the point nowadays of the extra training in child psychiatry, no less the strain of taking board exams, if one does not have access to child patients? The workforce recommendations cited in the article hardly seem practical in the current economic climate.

ROBERT T. FINTZY, M.D.
Pacific Palisades, Calif.

ADHD and Injury

The article in the April 6 issue on the lawsuits charging APA and Novartis Pharmaceuticals with conspiracy to create the diagnosis of attention deficit/hyperactivity disorder as a way to build a market for Ritalin once again brings the issue of medicating America's children to the forefront. Among the arguments offered by the plaintiffs is that the behavioral component of ADHD has been greatly inflated by APA, causing "normal childhood behavior" to be construed socially and clinically as pathological and thus requiring treatment.

Although the medical literature demonstrates that behavioral problems correlate with higher rates of unintentional injury in children, many psychiatrists and the media overlook the most dangerous threat to child and adolescent lives. Instead, social behavior and school performance are used as clinical thresholds for a diagnosis of ADHD.

As unintentional injury is the leading cause of death in children and young adults, one may speculate that the consequences of severe ADHD symptoms may be a shortened life expectancy. There is a relationship between ADHD and accident proneness in childhood, as well as with speeding and auto accidents in adolescents and young adults. Young people with poor attention are at greater risk of traffic violations, involvement in accidents, and drinking while driving. Cognitive factors of lower expectations of personal risk in hazardous situations are linked with less ability to generate prevention strategies. Thus, the ability to recognize hazardous situations and in turn develop safety strategies are important life-saving skills that ADHD patients may need to develop.

Pediatricians traditionally have been responsible for legislative initiatives to reduce injury, serving as an excellent model for psychiatry's role in public health. Prevention strategies need to be developed that target those with behavioral risk factors of unintentional injury, and these strategies should be incorporated into practice. Psychiatrists are bound, as all physicians are, to educate those at risk for illness or injury. Until APA establishes practice guidelines for ADHD, an active role in emphasizing these risks to patients may be the first step for us.

An important part of any evaluation or monitoring of a patient with ADHD is a history of unintentional injuries, including driving violations. For physicians treating children and adolescents with ADHD, it is important to discuss impulsive behavior and encourage patients and their parents to be vigilant about safety and safety consciousness. For example, a young boy with ADHD who has frequent accidents while driving a motor scooter is at risk for repeated injury later in life, and potentially more serious injury when driving an automobile.

Frequently, doctors consider improvement in school functioning and behavior at home when deciding on the adequacy and timing of treatment with medication. They should also consider the potential for injury if patients with ADHD are not adequately treated. The driving performance of young adults who have ADHD has been shown to improve significantly by taking stimulant medication.

The road signs are clear: a comprehensive approach to injury risk assessment and prevention with adolescents and young adults with ADHD saves lives.

MICHAEL ANDERSON, M.D.
JOHN B. STEA, M.D.
CHRISTINA G. WESTON, M.D.
Dayton, Ohio

Life Satisfaction

In my practice I have repeatedly seen that many presenting complaints, such as anxiety, depression, and irritability, are due to life dissatisfaction, as opposed to manifestations of major psychiatric disorders. The article "Study Finds Link Between Life Satisfaction, Suicide Risk" in the April 6 issue objectively studies what I have been anecdotally observing over the last several years. There is a need for psychiatrists to focus on the importance of such issues as interest in life, happiness, general ease of living, and feelings of loneliness and how they relate to mental wellness.

Ever since the beginning of my psychiatry residency training, complaints related to such "soft" quality-of-life variables have been minimized. The clinical focus was always on the signs and symptoms of more severe *DSM* diagnoses. This probably follows from psychiatrists' current orientation along a distinctly medical model to treat a disorder and attempt to attain baseline, or adequate, functioning. Many of the patients I see in my practice are dissatisfied with their lives, yet they are functional and lack significant psychopathology. Traditional psychotherapies, particularly psychoanalytically focused ones, have been of limited value with these patients.

I have been getting extremely good results by using a model that approaches these individuals not as mentally ill, but as not yet functioning at their highest level. This is a model based on achievement and peak performance technologies. It has been developed from linguistic patterns, the understanding of how belief systems are established and abolished and modeling the effective strategies of others who have proven success in varying life areas (success leaves clues). It also has its roots in Ericksonian indirect hypnotic techniques and Neuro-Linguistic Programming. These patients find this approach exciting because the focus is in unlocking their drives and potential, with the goal of striving for outstanding life success, rather than simply attenuation of psychiatric symptoms.

The article notes that those individuals scoring higher (less satisfied) on the Finnish researchers' Life Satisfaction Questionnaire were more likely to have been smokers or heavy alcohol users. As an addiction psychiatrist in private practice, I have seen how this peak-performance model is extremely useful for individuals in recovery from substance abuse. Some have been able to initiate sobriety and clean time by this approach. The most frequent complaint from those in early recovery is despair about their life situation now that substances are out of the picture. Alcoholics Anonymous and 12-step-oriented rehabilitation facilities attempt to deal with this despair by an immersion experience in the 12-step belief system. The validity of this belief system must be accepted and incorporated into the individual's mind as an absolute belief for "true" recovery. If not, the message is that recovery may not be attainable. I treat many people who are unable or unwilling to adopt this belief system, and thus they increasingly despair over the inability to change their perceptions about their life situation. Using exercises and techniques via this empowerment model, I have been able to teach and coach these individuals to install confidence-enhancing belief systems, attenuate limiting belief systems, establish congruence and rapport with themselves and others, and more consistently attain their life goals.

Both this article and my experience demonstrate that none of us should minimize "existential angst" in our patients. We see in the worst case that the end result could be suicide.

STEPHEN GILMAN, M.D.
New York, N.Y.

Vermont Controversy

An article appearing in the May 18 issue, "Vermont's New Hospital: Progress or Step Back?," contained a quote attributed to me in which I characterize psychiatry faculty criticism of Fletcher Allen Health Care and a plan to move mental health services to a new facility as "insubordinate." I would like to clarify my position on this matter.

At no time have I made statements, in public or private, concerning retribution for faculty that have opinions that are contrary to Fletcher Allen Health Care or University of Vermont College of Medicine positions. I completely hold to the principle that everyone is entitled to [his or her] own opinion and that a basic tenet of a healthy academic environment is open discourse.

This is an academic medical center. Whenever there is a new proposal or a new project, questions are raised. That's part of the process in this type of environment. New ideas are probed and questioned, and in the end a stronger, better product emerges. An academic medical center setting thrives on a culture of inquiry and questioning. The notion of a gag order or other such retribution would be an anathema to the academic setting.

The proposed mental health service move is a sensitive issue. However, the inpatient psychiatry faculty and staff and state officials are moving toward solutions to issues that have been raised. In the final analysis, I am confident that we will relocate our inpatient mental health services in a manner that will allow us to offer the very best, high-quality care we can possibly provide to patients in our region.

JOHN BRUMSTED, M.D.
Burlington, Vt.

Member Input

In a letter in the June 15 issue, Dr. David Dawes objected to the Board of Trustees' taking a position on gay marriages without first soliciting members' ideas on the subject.

Though I support the Board's position, I think Dr. Dawes, with whom I have had private correspondence, has a really good idea.

Does APA currently have any such mechanism to solicit members' reactions to positions or actions that the Board is considering? If not, could such a mechanism be developed? I believe the membership would feel more "ownership" of Board decisions if they were given an opportunity to offer their input prior to decision making.

JOSEPH S. SILVERMAN, M.D.
Altoona, Pa.

APA President Richard Harding, M.D., responds:

I know I speak for the Board of Trustees in welcoming Dr. Silverman's interest in having members' input on Board actions and discussions. This is an excellent idea that Web-based technology now makes feasible. Using the APA Web site, we will begin experimenting with putting selected agenda items, such as proposed position statements, online for members' comments and discussion as much in advance of Board meetings as possible.

We expect this feature to be working before the next Board meeting, which is being held October 8 and 9. The Board welcomes members' comments on how well this new feature works, along with thoughtful opinions from our fellow members that would help guide our thoughts and ultimately our votes on these critical issues. ■

Lawsuits

continued from page 1

and other defendants if plaintiffs file an amended complaint.

APA President Richard Harding, M.D., believes that the court's dismissal of the Texas and California lawsuits "sent a message to the plaintiffs in Florida" that their allegations were "unfounded and part of an antiscience, antimedicine agenda that could not succeed."

In a July 24 press release, Harding called the demise of the Florida lawsuit "an important victory for parents and children and a victory for good medicine and sound science."

"The litigation was an assault on the rights of patients to act in the best interests of their children and get them the help they need and deserve," said APA Medical Director Steven Mirin, M.D., in the press release. He condemned the plaintiffs for trying to deny the existence of a psychiatric disorder "that affects millions of children."

Novartis also hailed the end of the Florida suit, saying that it is "extremely pleased" that the plaintiffs decided to withdraw their legal action. Their decision

"The litigation was an assault on the rights of patients to act in the best interests of their children...."

"supports Novartis's position that this lawsuit and others like it are an unmerited attempt to promote an agenda that contradicts scientific and medical consensus" about ADHD and its treatments, the company's general counsel, Dorothy Watson, stated in a July 23 press release.

Ritalin was introduced in 1955 by Ciba-Geigy, which in 1997 merged with Sandoz Pharmaceuticals to form Novartis. The company is headquartered in Switzerland, and its U.S. operation is based in New Jersey. ■

government news

Jail Program

continued from page 9

Here is how the program works for inmates diagnosed with serious mental illness: Two to three months before the inmate's release, the correctional center's mental health discharge planner screens the inmate for eligibility—almost all are eligible. Inmates who are U.S. citizens do not need to furnish any identification; however, they must write their Social Security number on the application, said Richard McGreal, director of external affairs for the Massachusetts Division of Medical Assistance. "Those who are not U.S. citizens need to provide documents showing their immigration status."

After helping the inmate complete the application, the discharge planner flags the application with big stickers stating, "Pre-release Incarcerated" and includes a letter with the planner's name and telephone number.

When the application is received by MassHealth's Central Processing Unit, the information is entered into the computer system. This generates a letter stating that the application was rejected because the individual is in a correctional facility. It also cites any additional reasons for rejection.

However, all the information from the application stays in the system.

Upon an inmate's release, his or her file is activated. A mental health worker at a local community mental health center (CMHC) does this during a session with the inmate. The session is scheduled within five days of the individual's release, because inmates only receive a five-day supply of psychiatric medication.

On the day of release, the inmate is given a letter addressed to a local CMHC stating that his or her application is on file. Also, the correctional center faxes a letter to the regional MassHealth enrollment center notifying it of the individual's release.

Upon arriving for his or her appointment at the CMHC, the former inmate gives the mental health worker the letter from the correctional center. Then the mental health worker calls the local MassHealth enrollment office and tells staff there that the individual's application is on file and provides any necessary information. The former inmate can select a medical plan and physician over the phone.

The inmate's account becomes active immediately. Not only is the charge for the CMHC appointment covered, but the ex-inmate can also fill the 30-day prescription for psychiatric medication furnished by correctional center medical staff.

Reflecting on the program, Gallagher said, "The Medicaid office has not turned down a single application. And since this initiative has been in place, former inmates are able to receive mental health services and medication far more easily than in the past." ■

Parity Laws

continued from page 8

as they do for other drugs.

In contrast to the Rhode Island law, mental health coverage is not mandated. As a concession to the insurance industry's concern that removing the lifetime cap on outpatient visits would drive up premiums, parity proponents agreed to restrict parity to "biologically based" illnesses including schizophrenia, major depression, bipolar disorder, attention deficit/hyperactivity disorder, and autism, according to the July/August *Health Affairs*.

In other news, Delaware's Gov. Ruth Ann Minner (D) signed legislation (HB 100) that amends the state's 1998 parity law. Drug and alcohol dependency was added to the list of nine serious mental illnesses covered in the previous law. Although the bill's sponsors introduced a comprehensive parity bill, only the substance abuse provision passed, according to Paula Johnson, deputy director for state affairs in APA's Division of Government Relations.

The state parity laws are summarized in the July "State of the States" newsletter on APA's Web site. It can be accessed by going to <www.psych.org/libr_publ/state_up.cfm> and clicking "July 2001." ■

Prisons

continued from page 13

time than other prisoners with the same sentences.

The program will also include a forensic psychiatric fellowship, serve as a training site for medical students and residents, and will be a "gold mine" for research, he said. Silberfarb expects that logical areas of exploration will include research on questions like the psychiatric needs of geriatric prisoners, those with schizophrenia, or prisoners with a mental illness combined with drug or alcohol abuse.

"Forensic 'exposure' is required as part of the medical school curriculum," said Silberfarb. "The only way to learn is to take care of sick people. . . .A rotation through a prison exposes future doctors to [a range of] psychiatric illness at all levels."

Win-Win Situation

"These kinds of agreements work well for both parties," said Jeffrey Metzner, M.D., a clinical professor of psychiatry at the University of Colorado Health Science Center and president of the American Academy of Psychiatry and the Law. "Prisons get high-quality psychiatric services, and association with an academic medical center can overcome some of the problems prison systems have in recruiting professionals."

According to a 1999 report from the U.S. Bureau of Justice Statistics, 16 percent of all inmates in state prisons or local jails said they had a mental or emotional condition or had at least one overnight stay in a mental hospital. Only 6 of 10 mentally ill state prisoners, however, reported receiving mental health treatment since admission to prison.

Metzner agrees that 10 percent to 14 percent of the total prison population can be considered part of the mental health caseload at any given moment and that 15 percent to 20 percent have been treated at some time. Prisoners are the only group in the United States with a constitutional right to treatment of mental illness.

"Seriously mentally ill [prisoners] must have reasonable access to services," said Metzner, who is also chair of APA's Council on Psychiatry and Law.

How states provide such access varies widely. Some states hire their own professionals. Others contract with private companies, which then hire physicians, he said, while non-M.D.s remain state civil service employees. A few other states contract with nonprofit companies run by university medical centers, gaining their expertise without for-profit baggage. In Texas, for instance, the University of Texas Medical Branch at Galveston covers the eastern portion of the state (and 80 percent of the prisoners), while Texas Tech University handles the west.

Individual Contracting Didn't Work

Prior to signing with Dartmouth, New Hampshire's Department of Corrections contracted with individual psychiatrists for treatment of mentally ill inmates, said Linda Flynn, M.S., A.R.N.P., director of the department's Division of Forensic and Medical Services, which looks after 2,400 prisoners. However, the drawbacks of that practice became increasingly apparent.

"Individual contracting created difficulties in staffing, since each doctor worked a different number of hours or had conflicting time commitments," said Flynn. "We became concerned about responsiveness and service delivery.

"This is a challenging patient population. Incoming inmates are at a crisis point in their lives and may be depressed in view of their circumstances. And there are many with dual diagnoses—mental illness and substance abuse. Once they enter prison, they can no longer use those substances to self-medicate. We needed a change."

Flynn said Dartmouth's program has been slow getting off the ground because of delays in hiring a director. Once that person is on board, she expects that the needs of the inmate population at each facility will get a close look, followed by appropriate planning for patient needs.

Perhaps any changes in the prison psychiatric system will mirror the ones brought about at the New Hampshire Hospital (NHH) after Dartmouth's psychiatry department became responsible for care there 13 years ago.

"We would expect to see an increase in the number of psychiatrists and their level of expertise, which would allow nurses, psychologists, and social workers to function at a higher skill level," said Robert Vidaver, M.D., medical director at the NHH and a professor and vice chair of the psychiatry department at Dartmouth. "The use of drugs, psychotherapy, groups, and programming changes came to reflect academic levels of sophistication. This led to better diagnosis, improved therapies, a dramatic improvement in the ambiance."

The arrangement should benefit those providing care as well, said Vidaver.

"If they are not put off by stigma and fear, I think our students and residents will find that patients who are prisoners are ordinary human beings. Any time you can give medical students a sense of what goes on in these facilities, you expand their vision, and perhaps a small proportion of them will take jobs in the public sector." ■

Depression

continued from page 18

approval for treating persons with treatment-resistant depression, what would that mean for American psychiatrists and their patients? "It would be the first new physical treatment with substantial efficacy since we discovered electroconvulsive therapy in 1938," George replied. "So it would be revolutionary."

But how about costs? The device and implantation of it currently run about $15,000. Subsequent visits to a psychiatrist to switch on electrical stimulation of the device or otherwise modulate it would, of course, cost extra. But current treatments for treatment-resistant depression aren't cheap, either. Or as George pointed out: "I treat lots of people with treatment-resistant depression. It is a very costly illness. Patients tend to need frequent doctor visits and are often on very costly polypharmacy. They also require intermittent hospitalization. . . . A short course of ECT. . .can easily run around $15,000 or $20,000. So you can see that if the device were effective, it would make a lot of sense for an HMO or managed care company to pay for it because it would actually save money in the long run."

As far as NCP System treatment for refractory epilepsy goes, most major American health insurance companies and Medicare pay for it, George added. ■

Teachers

continued from page 2

are on Prozac, Thorazine, Haldol . . .It blows my mind," she said in a July 17 article in the *New York Times*. "It's easier to give somebody a pill than to get to the bottom of the problem." She characterized this use of medication with school children as "a quick fix" for behavior problems.

Winkler indicated that she is troubled by accounts of school personnel recommending specific medications that students should be prescribed when the teachers and guidance counselors do not have the training to draw such conclusions.

In a press release posted on the Connecticut state Web site, Winkler said she is also concerned about the long-term effects of psychoactive drugs when they are prescribed for children. "There is some evidence that teenagers and adults who have been involved in terrible acts of violence were treated with psychiatric drugs as children. Clearly we need to know more about these medications and what they are doing not only to the children of today, but to the teenagers and adults of tomorrow."

She emphasized that she is not opposed to having children take psychoactive drugs if the suggestion to do so comes from a physician who has evaluated the child thoroughly, something school personnel cannot do.

The text of the bill can be accessed on the Web at <www.cga.state.ct.us/> by clicking on "Public Act" in the "Quick Search By" box, entering 124 in the box labeled "No.," and clicking on "Public Act No. 01-124." ■

from the president

continued from page 3

governance, meeting logistics, and CME. The Board was informed by the work group that this option would require significant internal and external organizational change, staff development, and considerable simplification of APA and district branch business practices for this to be a viable option.

Option 3 was an "off-the-shelf" data management system similar to Option 2, but we learned that this option, while not requiring major changes in how APA and the district branches "do business," would take longer to implement with significantly more associated costs.

After extensive discussion the Board of Trustees voted to approve the work group's recommendation that we proceed with a hybrid of Options 1 and 2. Specifically the work group recommended that in the short term, that is, immediately, staff work to resolve membership dues-billing and payment-processing issues by putting more fiscal and human resources into assuring that the 2002 dues-billing cycle goes smoothly. Two skilled accounting employees have been brought on board to assist in dues processing and to resolve the inevitable problems that will arise as a result of the interplay of our current system and complex business practices. At the same time, the work group, aided by additional representation from the district branches, will work with staff to review APA/DB business rules and practices with the goal of simplifying and streamlining them to prepare for a move to an integrated "off-the-shelf" data-management system for the Association.

The expanded work group will be reviewing membership policies and procedures and will ask district branches for ideas and feedback concerning potential changes. In addition, the work group will evaluate available "off-the-shelf" association data-management systems in terms of their applicability to APA, their relative cost, and the experience of other medical associations in implementing an integrated information system plan using this type of software.

At the fall component meetings next month, the work group will work on both these short-term and long-term goals with input from the District Branch Advisory Committee focusing on how we might simplify our membership business rules and practices. Updates and progress reports will be given to the Board of Trustees at its October and December meetings and to the Assembly at its November meeting. The Board will hear final recommendations on simplification and streamlining of business rules at its March 2002 meeting.

To summarize, APA has been handicapped by trying to keep a 12-year-old information system patched together and functional. It is long past the time for a fully integrated membership and business system that will allow district branches and individual members to access their membership files and individual accounts, apply for CME credits, register for meetings, and interact with other parts of APA in real time and with a minimum of hassle. To make this system work, we must strive to unify the business and membership rules under which we function Association-wide. I am pleased with the problem-solving ability of our volunteer members and leaders and our valued staff as we build the infrastructure for an efficient 21st-century APA. ■