

PSYCHIATRIC NEWS

“See” references (such as “see illustration...”) appear on pages 7, 10, 16, and 32.

Top stories are listed in top stories file.

Government News

Senate Committee Backs Stronger Mental Health Parity Mandate

With the clock ticking before the 1996 parity law sunsets at the end of this month, a Senate health committee votes unanimously to pass a more comprehensive parity bill.

BY CHRISTINE LEHMANN

A federal parity bill that would require health plans covering mental illnesses to remove discriminatory treatment limits and financial requirements sailed through the Senate Health, Education, Labor, and Pensions (HELP) Committee last month.

APA Medical Director Steven Mirin, M.D., praised the committee’s swift and unanimous passage of the improved parity bill. “APA looks forward to passing S 543 into law to ensure psychiatric patients receiving the quality mental health treatment they need and deserve. This is a giant step towards ending insurance industry practices that discriminate against mental illness,” Mirin told *Psychiatric News*.

He attended the committee mark-up with representatives of mental health advocacy groups and Rep. Patrick Kennedy (D-R.I.), a key cosponsor of a House parity bill (HR 162) introduced by Rep. Marge Roukema (R-N.J.) in March.

The group demonstrated its support for parity legislation by walking together from Kennedy’s office to the committee session, where they were greeted by cosponsors Sen. Paul Wellstone (D-Minn.) and HELP com-

see *Parity Bill* on page 30



APA Medical Director Steven Mirin, M.D. (right), joins parity bill cosponsors Rep. Patrick Kennedy (D-R.I.) (left) and Sen. Paul Wellstone (D-Minn.) (second from left) before the Senate HELP Committee mark-up last month. In background, Michael Faenza, president of the National Mental Health Association, talks to Chris Koyanagi, policy director of the Bazelon Center for Mental Health Law. See story at right.

Professional News

Menninger Calls Off Texas Move, Looks for New Partner

Deciding that the eyes of Texas are not upon it after all, Menninger has rethought its much-publicized decision to move to Houston and form a partnership with Baylor College of Medicine.

BY KEN HAUSMAN

The marriage is off. After months of negotiation Menninger has decided that its future does not lie in a much-ballyhooed union with Baylor College of Medicine and Methodist Health Care System.

The merger agreement, which was announced last fall, would have seen the prestigious psychiatric hospital leave its Topeka, Kan., home of 76 years and relocate to Houston where it would form a new alliance with the medical school and hospital system (*Psychiatric News*, November 2, 2000).

The proposed move caused considerable consternation in Topeka, where Menninger is a major employer and source of pride, and in psychiatric circles throughout the U.S., particularly among the hundreds of psychiatrists who received their training at Menninger.

Menninger and its Houston partners had planned to establish a “national center” for state-of-the-art psychiatric care and a research institute to conduct brain and behavioral research. As part of the partnership agreement Baylor’s psychiatry department was eventually to be renamed the Menninger department of psychiatry. Menninger’s psychiatry residency program was to move to Houston as well.

In announcing its planned affiliation last September, Menninger officials indicated that their move was motivated by fi-

nancial concerns, which they attributed to the changing U.S. health care reimbursement climate. The hospital has watched its income decline for several years as a result of shrinking inpatient stays, fewer patients being admitted, and a steady erosion in payments from insurance companies.

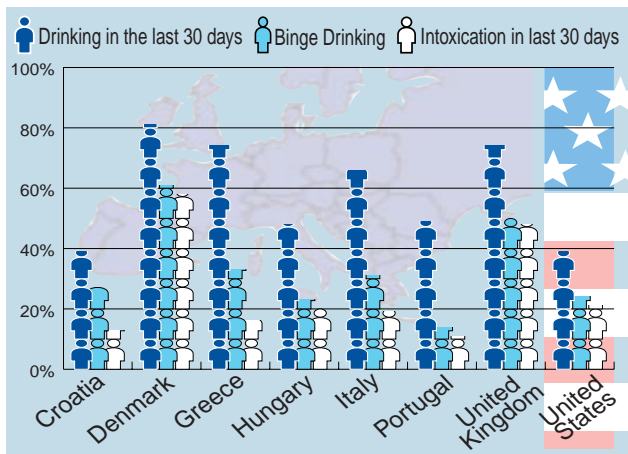
Maintaining its 242-acre campus, which has served as Menninger’s home since 1925, as well as the buildings on it has also become an increasing expensive proposition.

The income drop combined with skyrocketing operating costs forced Menninger to dip into its \$100-million endowment to the tune of \$12 million in 1999, and its trustees see no hope for a reversal of those trends.

Even though Menninger has laid off half of its 900 Topeka-based employees in the last year, it has not been able to return to profitability.

Menninger CEO Walter Menninger, M.D., said in a July 31 statement announcing the end of the negotiations, “Everyone see *Menninger* on page 33

Indicators of Problematic Drinking in Youth



The U.S. fares well against most European countries in terms of youth drinking. See story on page 10.

Source: U.S. Department of Justice, Office of Justice Programs

Appeals Court Upholds Judge's Order To Medicate Capitol Hill Shooter

A recent federal ruling indicates an evolution in the attitudes of courts toward antipsychotic medication.

BY KATE MULLIGAN

On July 27 a three-judge panel of the U.S. Court of Appeals for the D.C. Circuit upheld a ruling by District Judge Emmet G. Sullivan last March that Russell Weston can be forcibly medicated for his symptoms of paranoid schizophrenia.

Weston is charged with the 1998 murder of two police officers in the U.S. Capitol but was found incompetent to stand trial because the severity of his symptoms made him incapable of participating in his own defense.

Weston has been confined in the psychiatric unit at the Federal Correctional Institute in Butner, N.C., since soon after the shootings. For much of that time he has been kept in an isolation cell where he has continued to deteriorate mentally and physically, according to testimony during prior hearings.

Sullivan originally agreed with the government and ordered that Weston be forcibly medicated, in part to reduce the chances that he could be dangerous to others or to himself. Defense attorneys immediately appealed, and the appeals court put the order on hold, telling Sullivan to go into more depth on the complex issues involved in involuntarily medicating a mentally ill suspect. After more hearings, the judge again ruled in favor of forced medication, stating that failure to medicate Weston with antipsychotics amounts to “simply the warehousing of Weston in a psychotic state.” The issue of medication is particularly controversial because the prosecutors have refused to rule out the option of requesting the death penalty if Weston is convicted.

Appeals Court Judge A. Raymond Randolph refuted several defense arguments

in the most recent ruling. He stated that the government’s interest in administering antipsychotic drugs to make Weston competent for trial overrode his “liberty interests” and added, “The government’s interest in finding, convicting, and punishing criminals reaches its zenith when the crime is the murder of federal police officers in a place crowded with bystanders where a branch of government conducts its business.”

Defense attorneys said that medication would not restore Weston’s competence to stand trial because he was not likely to re-

“The decision represents a triumph for common sense in an area of law not always ruled by that virtue.”

spond to it and also claimed that the “medication’s mind-altering properties and likely side effects would prejudice his right to a fair trial. . . .”

The appeals court, however, found “a sufficient likelihood that antipsychotic medication will restore Weston’s competence” and would “improve Weston’s ability to relate his belief system to the jury.”

APA President-elect Paul Appelbaum, M.D., a forensic psychiatrist, said, “The decision represents a triumph for common sense in an area of law not always ruled by that virtue. In addition to recognizing that society has an important interest in trying defendants who have committed major crimes, the court also portrayed antipsychotic medications in a more realistic light than has been seen in many cases. The judges recognized that proper treatment with antipsychotics is likely to improve Weston’s mental functioning, rather than to impair it, as his attorneys alleged.”

Forensic psychiatrist Jack Schoenholtz, M.D., a clinical professor of psychiatry and behavioral sciences at New York Medical College, emphasized, “We should not medicate Weston to have him appear competent to stand trial. The job of a doctor here must not be to serve the interests of the state. However, since he is in the state’s custody, we have a duty to provide him whatever medical care he needs. Otherwise, we violate the Eighth Amendment’s prohibition on cruel and unusual punishment.”

The contrast between the Weston
see Medication Order on page 8

New Opportunity to Help APA Advance Psychiatry's Issues

BY RICHARD HARDING, M.D.

A major reason for APA's 2001 reorganization is to enable the association to invigorate its patient and professional advocacy activities. APA is currently committing substantial financial support to the local district branches and state associations for priority grass-roots advocacy issues. To complement this strategy we are establishing a political action committee that allows APA, at the national level, to educate and lobby members of the House and Senate of the U.S. Congress.

Knowing this goal must be achieved, and to create the necessary infrastructure to carry it out, your Board of Trustees voted unanimously to establish the American Psychiatric Association–Political Action Committee (APA-PAC).

The purpose of the APA-PAC is to advance the interest of psychiatry in public forums and to represent these interests before legislative and other government bodies. These goals are achieved by working through the political process by supporting candidates who are committed to assisting those suffering from mental illness, including addictive disorders.



The APA-PAC provides a way to combine smaller donations from individual psychiatrists and give them in one larger, more impressive contribution to an elected official or candidate on behalf of the entire profession.

These contributions go a long way in allowing APA-PAC

contributors to target key fund-raising events, set up grass-roots educational meetings between APA members and elected officials, and provide other opportunities for APA members to have access to key members of Congress.

Why is this important? As APA members, we must be certain that laws are not made and regulations are not established that would negatively impact on our practice of psychiatry and on psychiatric patients without the opportunity for prior education and comment from psychiatrists themselves. APA-PAC will help to ensure not only the election of members of Congress who share mutual principles and goals with APA, but also stand up for our position during the legislative process. It also helps educate other members of Congress as to why they should support

see *From the President* on page 27

When Disaster Strikes, Psychiatrist Is on His Way

When major disasters devastate communities anywhere in the U.S., a New Mexico psychiatrist is ready to board a plane and begin helping victims patch their physical and psychic wounds.

BY MARK MORAN

Psychiatrists don't normally find themselves delivering babies or running makeshift emergency hospitals. But APA's Area 7 trustee, Albert Vogel, M.D., seems to be expanding his repertoire of medical experience beyond the typical and into the unpredictable.

As head of the New Mexico Disaster Medical Assistance Team, Vogel is the only psychiatrist to command one of the approximately 28 level-one disaster-relief teams sponsored by the National Disaster Medical System (NDMS). The NDMS draws together the resources and expertise of several federal agencies—the U.S. Public Health Service, Department of Defense, Veterans Administration, and Federal Emergency Management Agency—to bring medical care to disaster victims around the country.

For example, there was a pregnant woman for whom the team performed a Caesarian section in the aftermath of Hurricane Hugo on the Island of St. Croix. More recently, in the wake of the flood that shut down the city of Houston, Vogel was responsible for establishing and administering a temporary emergency department for disaster victims.

In 1984 Vogel's team was the first to be formed west of the Mississippi. More teams are forming, and there are efforts to regionalize services and to rotate a call schedule. But in practice, Vogel said, the teams go whenever and wherever they are needed.

"We have gone as far as the Virgin Islands for Hurricane Hugo and Hawaii for Hurricane Iniki," Vogel noted.

And his team appears to have done it all when it comes to disasters: earthquakes, fires, and floods. Most recently, Vogel and his team were sent on very short notice to help provide relief to Houston flood victims in early June.

"We got the call on Saturday about 8:30 in the morning and were put on alert status," he recalled. "By 11 a.m. we were activated, and we were in Houston in 24 hours."

Twenty-five team members and 28,000

pounds of gear made the trip on an Air Force C-17. The mission was to set up a makeshift emergency department in the exhibition hall of the Houston Astrodome to serve the overflow of patients from the city's overextended—and sometimes flooded—emergency rooms.

"Our goal was to help decompress the city's ERs, which were overwhelmed," Vogel said. "Many of the basements of hospitals were flooded, shorting out electricity and computers."

Working closely with the city's emergency medical service, the team's goal was to treat not major medical emergencies, but the lesser emergencies that couldn't be handled at the city's hospitals. "We started seeing patients on Monday at 8 a.m. and stayed until the next Sunday at 3 p.m.," he said. "We saw almost 600 patients. Most had minor to moderate medical emergencies. We saw some psychiatric emergencies, but not many—acute stress disorders and some

"Our goal was to help decompress the city's ERs, which were overwhelmed."

folks with chronic, severe mental illness who couldn't get their medications."

The Houston experience is typical in at least one way, Vogel explained. "What has been surprising to the whole NDMS system is that the vast majority of our deployments have not been to treat the direct disaster injuries, most of which are taken care of by the time we get there. What we are doing, instead," he noted, "is providing typical medical care to people whose regular medical systems have been destroyed. Until the big one comes along, what we do is provide care to people very much like in an urgent care center."

A typical scenario, for instance, is treatment of children with asthma, whose condition is exacerbated by the stress of the disaster, but who cannot access medical care through their usual sources. Also common

are injuries and emergencies resulting from "residual damage," such as auto accidents, he said.

From a psychiatric perspective, earthquakes can be the most tumultuous event, with their recurrent aftershocks that rob victims of a sense of immediate closure. During the 1994 earthquake in Northridge, Calif., for example, the number of casualties—both physical and emotional—continued to mount even after the main quake was over.

In contrast, Vogel says, a hurricane does its damage and is over.

"After an earthquake



The New Mexico Medical Disaster Assistance Team aboard an Air Force C-17 cargo plane for the trip to Houston. Psychiatrist Albert Vogel, M.D., is in right foreground wearing an earplug.

the ground is still shaking," Vogel pointed out. "The aftershocks can be very strong and can cause damage, literally knocking some buildings down. From a psychiatric point of view, the continual changing of the ground increases and prolongs the stress."

Austere Environment

So what does it take to practice disaster medicine?

Vogel says practicing disaster medicine means a tolerance for the kind of rapid, high-stress, medical improvisation typical of an episode of the television show, "ER."

"What it takes is the ability to function in an austere environment when you are in a tent and the ground is shaking and there is no power, trying to provide the best medical care you can provide," Vogel explained.

Some team members receive training in "critical-incident stress management," designed to help those members of a community—especially police and emergency medical personnel—who are likely to be the first responders to the most horrific sequelae of a disaster. As Vogel said, "It's designed to help people who have to pick up body parts."

Not that every disaster situation is so dramatic. "What we do depends on the situation when we get there," he said. "We have gone to a site and done nothing. Occasionally, we get prepositioned for a hurricane and turn around and come home because the hurricane didn't cause enough damage or injury for our team to be needed."

But even in those infrequent situations, the NDMS teams are supplying a critical preventive function. And yes, team members have regular day jobs—so hopping on a plane at a moment's notice is not all fun and games.

Job Arrangements

"All of our people have to get permission from their employers to take leave," he notes. "That creates an interesting problem, especially with nurses. The shortage of nurses makes it harder on employers to allow staff to take 10 days or so. We would like to get as much publicity as possible about what we do when we are deployed, so that employers know that when their personnel are off for 10 days, they are providing a valuable clinical service and not going out and playing in the sand."

Team members are paid during deployment as temporary employees of the U.S.

Public Health Service, but are not paid for the four training sessions that take place each year. In any case, however, money is clearly not why doctors and other health care professionals work in disaster relief.

So why do they do it?

"The answer is simple," Vogel said. "It provides a lot of satisfaction. You have the experience of getting help to people who really don't have any other source of help."

And Vogel believes his work as commander of a disaster medical assistance team is a model for younger psychiatrists seeking ways to diversify their careers.

"There are other niches for psychiatrists, other than just practicing psychiatry, per se," he pointed out. "Psychiatrists have a lot to offer in the provision of disaster medical care, both from the point of view of treating psychiatric conditions—including those that present during disaster settings unrelated to the disaster—as well as psychiatric complications of a disaster. But they also have a role in managing and organizing care in disaster settings. There is the challenge and reward of getting 35 people out the door in 24 hours and allowing them to provide the care that is needed to people who need it." ■

Residents Selected

Ten psychiatry residents have been chosen to participate in the APA/Glaxo-SmithKline Fellowship program. The two-year fellowships provide residents who demonstrate leadership potential with the opportunity to work with APA leaders at the national level to familiarize the residents with the many areas in which APA is active.

The following residents have been selected for the 2001-2003 fellowships: Mariabel Abbate, M.D., State University of New York at Buffalo; Amin Azzam, M.D., University of California, San Francisco; Ned Bhanji, M.D., McGill University; Judith Gold, M.D., Cornell University; Paul Holtzheimer III, M.D., University of Washington; Andrew J. Kolodny M.D., Mt. Sinai School of Medicine; Kishor E. Malavade, M.D., New York University Medical Center; Seema Malhotra, M.D., Western Psychiatric Institute and Clinic; Joanna Steinglass, M.D., New York State Psychiatric Institute; and Laurel Lyn Williams, D.O., Baylor College of Medicine. ■



Al Vogel, M.D., (in red shirt) briefs some of the most senior of the VIPs to visit the New Mexico Medical Disaster Assistance Team in Houston. Pictured with Vogel are Lacy Suiter (with hand on chin), executive associate director of the Federal Emergency Management Agency, with his staff, and representatives of the U.S. Air Force 591st Expeditionary Medical Squadron from W. Hall Medical Center, Lackland Air Force Base, San Antonio.

Program Seeks Ways to Increase Access to Depression Treatment

The Robert Wood Johnson Foundation and a psychiatric research expert are working together to expand the availability of effective depression treatment at the primary care level.

As any psychiatrist knows, highly effective treatments for depression exist, yet many Americans are not getting the treatment they desperately need.

But suppose new ways to pay for depression treatment in primary-care settings were created. Suppose more stakeholders in effective depression treatment at the primary-care level, such as employers, got involved. And suppose young “turks” among primary-care physicians could be recruited to expand depression treatment. Would these efforts make effective depression treatment available to more Americans who need it?

The Robert Wood Johnson Foundation hopes so. And so does Harold Pincus, M.D., executive vice-chair of psychiatry at the University of Pittsburgh and a former director of research for APA. In fact, they are teaming up to answer these questions through a program called Depression in Primary Care: Linking Clinical and System Strategies. The foundation will provide \$12 million for the program, which is to run for five years, and Pincus will be serving as national program director.

The idea for the program started to crystallize in 1999. “It really came out of a collaborative effort, thinking and working with a lot of people at the Robert Wood Johnson Foundation,” Pincus explained to *Psychiatric News*. “It responded to a number of things that the foundation had as its major priorities. The foundation is particularly interested in issues surrounding chronic disease and around working at multiple levels to try to make changes in the health care system. And it was particularly interested in focusing on depression because there are a lot of good data demonstrating that depression is a severe and serious condition, with a lot of implications for individuals and their families and society, and also because there is a lot of evidence that we have treatments that are effective for depression, and not only effective treatments, but ways of utilizing those treatments [in the primary-care setting]. . . . The problem is that, although we know what to do, people don’t do it. So the foundation was interested in a multilevel approach to [expanding the availability of effective depression treatment at the primary-care level].”

The program became a reality in 2000. It consists of the following three components, labeled incentives, value, and leadership:

- Through the incentives component, the program will underwrite research projects to determine whether it is feasible to change the financing of depression treatment in primary care while at the same time improving the quality of treatment. In other words, Pincus explained, “The incentives component is where we are asking for partnerships to be formed between primary-care practices and health plans. . . . The idea is to have them work together and put into place a clinical-care model that we know is effective for the longitudinal care of de-

pression and an economic and reimbursement infrastructure” that will improve the way that care is paid for.

- In the value component, the program will underwrite research projects to explore other innovative ways of expanding effective depression treatment at the primary-care level, for example, by getting employers involved.

- Under the leadership component, the program will bring young primary-care

physicians and senior people in the depression-treatment field together to conduct research projects relevant to the program’s goals. The idea, Pincus said, “is to try to identify and develop future leaders in primary care and cultivate their interest in issues around depression and mental health by linking them to senior people in the depression field.”

Some 80 different health care professionals and payers have expressed interest in participating in the incentives component of the program. They comprise a wide spectrum, Jeanine Knox-Houtsinger, manager of the program, told *Psychiatric News*, for instance, academic teaching hospitals, pharmacy-benefit managers, HMOs, PPOs, even some mental health carveouts. At the end of July, representatives from these groups came to Pittsburgh at their

own expense to learn how to put together applications for grants in the incentives component of the program. Applications for these grants must be filed by September 28, and groups that are chosen to receive grants will be notified early in 2002.

A call for applications for grants to participate in either the value or leadership components of the program will be issued this fall.

When *Psychiatric News* asked Pincus what he hoped would come out of the program, he replied: “I hope it will change the way we take care of, and pay for the care of, people with depression.”

More information about the Depression in Primary Care: Linking Clinical and System Strategies program can be obtained from Jeanine Knox-Houtsinger by telephone at (412) 624-6589 or e-mail at knoxjv@msx.upmc.edu. ■

Health Officials Bringing Alzheimer's Care Back Home

Health department administrators in several states are finally acknowledging what patients and their families have known for some time: Home really is where the heart of Alzheimer's care should be.

BY JIM ROSACK

Faced with burgeoning populations of elderly citizens dealing with the dementia and behavioral disturbances characteristic of Alzheimer's disease, state departments of health responsible for dispersing Medicare and Medicaid funds are shopping for better, and cheaper, ways to care for the disabled and elderly in their communities.

Several states now agree with many patients and their advocates that not only are home- and community-based services preferable to nursing homes, but they can also save the state money as well.

"People vastly prefer alternatives to nursing home care," Larry Polivka, Ph.D., stated at the 10th annual National Alzheimer's Disease Education Conference, sponsored by the Alzheimer's Association in Chicago in July. "And alternatives, like home- and community-based residential programs, if properly funded and administered, are cost effective. All of the research done since 1992 leads to this conclusion." Polivka, a sociologist, is now the director of the University of South Florida's Center on Aging. Prior

to his joining the university, he was Florida's assistant secretary of health for aging and adult services.

The problem, Polivka told *Psychiatric News*, is that about 80 percent, of all public funds spent on patients with dementia are spent on nursing homes, while only 35 percent to 40 percent of total expenditures for developmentally disabled persons are spent on institutional care. That is, "In most states, we do a much better job of taking care of developmentally disabled patients in home and community programs than we do in taking care of dementia patients, including those with Alzheimer's disease," he explained.

According to Polivka, at most only 12 states have made substantial progress toward balancing their overall long-term-care systems between nursing homes and home- and community-based systems.

Working Toward Balance

Ideally, according to Polivka, a state should find a balance in which 45 percent to 65 percent of funds are spent on institutional care, and 35 percent to 55 per-

cent are spent on home- and community-based care. Florida officials, he noted, are working to achieve a 60 percent/40 percent balance after several years of crisis in the funding stream as more and more of the funds were "eaten up" by what Polivka characterized as inappropriate institutional care.

Reforming a state system to work toward that balance takes time, said Polivka. "On average, a state needs to devote five to 10 years in order to achieve that balance," he explained. "You have to develop systems and methods of shifting the state's resources, and you cannot neglect home- and community-based programs while you are working on the institutional realignment."

It is also important, Polivka told *Psychiatric News*, to develop rigorous management systems for home- and community-based systems and aging services networks, including managed long-term-care systems. States must also work to promote and expand private-pay options within the new system.

"At the same time," Polivka concluded, "you must constantly work toward improving quality of care and quality of life for patients who are in long-term-care facilities." A major component of ensuring high-quality care in the changing nursing home environment, Polivka said, is addressing workforce issues, including compensation, working conditions, and training.

Several states are ahead of Florida in successfully reforming their long-term-care systems, including California, Arizona, Oregon, and Michigan.

Since 1986 Michigan has been working to reform the way it cares for the disabled

and elderly, paying particular attention to patients with Alzheimer's disease.

"Alzheimer's disease is a specific line item in our \$8.7 billion budget," said James K. Haveman, Jr., director of Michigan's department of community health. "And the only reason it is a specific part is because of dedicated patients and advocates who worked hard to make it so. Three years ago a patient with Alzheimer's disease appeared before the [state legislature's] appropriations committee, telling the members that it was extremely important for her to testify because she probably would not be capable of doing so the following year." That, Haveman said, got legislators' attention, and ever since, specific funds have been earmarked for Alzheimer's care.

Starting From Scratch

Michigan found that in its quest to reform the way it cared for its rapidly increasing disabled and elderly population, it would literally have to scrap its current system and build a new system from the ground up.

In 1991, when Haveman began as director of the state's mental health department, the state had an unwieldy five geographic divisions, and services and care were splintered.

"After an intensive review, Governor John Engler in 1996 gave me 30 days to completely redesign health care in the state," Haveman told *Psychiatric News*. He responded by doing something drastic. He bucked the trend toward decentralized systems and brought the five health divisions

back into one department of community health. That required some serious streamlining, paring down 13,000 employees to about 6,000 today.

The result was a single, much larger revenue stream that could be more specifically earmarked and dedicated toward improving long-term care. Haveman also closed 15 state institutions for the developmentally disabled and mentally ill and shifted the care back to home- and community-based programs.

“I am a firm believer in comprehensive community efforts, building on private agency efforts to perfect the work that really makes a difference,” Haveman told the plenary session attendees. “Everyone with Alzheimer’s disease will require long-term care. On average, patients and their families endure 10 years of progressively worsening symptoms, with the majority of care occurring in the home. After about seven or eight years, a majority of patients will need some kind of out-of-home care.”

Providing strong support systems to families, Haveman said, has a direct impact on the length of time they are able to provide care for individuals with Alzheimer’s disease at home. It is important for coordinated service delivery systems to recognize

that there are effective drug, environmental, and social interventions that can delay the need for out of home care. But the key, Haveman emphasized, is early identification and intervention.

“A priority for reforming a system must be a focus on helping people who already have a place to live to keep their housing and be able to receive care there,” Haveman concluded. “Care from spouses, relatives, friends, and neighbors represents the bulk of services provided to persons who need long-term care. A work group that looked at the problem in Michigan recommended a significant expansion of services to support these caregivers as the most important means of increasing the overall quality of care, the patients’ and their caregivers’ quality of life, and making state programs more cost effective.”

Although a work in progress, the state’s reforms are already seeing an effect in reduced expenditures to nursing homes, increased decision making at the community level, and much greater access to care across the state, Haveman said.

More information about Michigan’s long-term-care system is available on the Department of Community Health’s Web site at <www.mdch.state.mi.us>. ■

Heeding Caregivers’ Needs

Several experts speaking at the 10th annual Alzheimer’s Education Conference in Chicaco in July agree that an integral part of reforming systems of care for patients with the progressively debilitating disease must focus on direct caregivers. To be successful, systems of care must address retention of quality employees in long-term-care facilities as well as quickly growing home- and community-based programs (see story on facing page).

With care for Alzheimer’s disease (AD) patients moving away from nursing homes, patients are increasingly being cared for not by paid, skilled workers, but by untrained, unpaid caregivers. It was estimated by the National Long Term Care Survey (NLTCS), reported last year by the Administration on Aging, that more than 7 million spouses, family members, friends, or neighbors are providing unpaid help to 4 million older people with functional limitations in a home setting.

According to the study, if these caregivers were replaced with paid home-care personnel, the cost of caring for these patients would increase between \$45 billion and \$94 billion annually.

The NLTCS data indicate that nearly 65 percent of noninstitutionalized patients who need health care assistance depend solely on family and friends, and 30 percent supplement that care with limited services from paid home care providers. Only about 5 percent rely solely on paid home care services.

Providing care in the home for a patient with AD is a huge responsibility, noted Rosemary Barrow, Ed.D., a sociologist and educational counselor at Stephens College in Columbia, Mo. She and Alice Anderson, a social worker with Educational and Human Services, also in Columbia, said that caregivers not only need to be educated on the disease but also on how to be a caregiver.

According to Alzheimer’s Association data, caregivers commonly experience depression, grief, and burnout, which hamper their efforts to take care of their loved ones. Emphasizing the use of community resources, Barrow said, helps to reduce caregiver stress. The biggest barrier to accessing resources, however, is caregivers not knowing what community-based support is available. It is essential, she said, that support programs have strong outreach efforts to make sure that their services are well known in the communities they serve.

Delores Moyer, a nurse practitioner who manages the direct caregiver staff at Harbor Senior Concepts in Middleton, Wis., said that providing support services to paid caregivers is just as crucial. Moyer and her colleagues surveyed nearly 500 employees at long-term-care facilities in nine states over 12 years. The results showed that retention of quality staff lies first in improved recruiting techniques, followed by giving rewards for excellent work, and support- and education-oriented activities focused on staff self-improvement and professional growth.

Mark Sager, M.D., director of the Wisconsin Alzheimer’s Institute (WAI) at the University of Wisconsin, agrees. WAI has developed a worker education, training, and assistance (WETA) model for the long-term-care industry, aimed at improving the quality of care by improving the quality of the staff.

In developing the WETA, WAI surveyed more than 700 long-term-care workers and found that low pay and benefits were not the only factors influencing the quality of care. Inadequate training, unreasonable work loads, lack of opportunity for advancement, little respect from supervisors, and lack of organizational recognition also contribute to workers’ high stress and translate into high turnover rates, which in turn reduce the quality of care.

The Administration on Aging report, “Implementing the National Family Caregiver Support Program,” including data from the National Long Term Care Survey, is available on the Web at <www.aoa.gov.carenetwork/report.html>; more information on WETA is available at <www.medsch.wisc.edu/wai/education.html>.

Medicaid Eligibility Termination Plagues Former Inmates

When inmates with mental illness begin their jail terms they often lose eligibility for Medicaid or federal disability benefits. When they are released, restoring that eligibility is often a time-consuming process, leaving many without health care coverage for a long time.

BY LIZ LIPTON

When inmates with mental illness are released from jail without SSI, SSDI, or Medicaid benefits, they are more likely to end up in the emergency room, prison, or back in jail, according to Chris Koyanagi, policy director at the Bazelon Center for Mental Health Law.

To help break this insidious cycle, Koyanagi wrote the March 2001 report "For People With Serious Mental Illness: Finding the Key to Successful Transition from Jail to Community: An Explanation of Federal Medicaid and Disability Program Rules." This report offers detailed information on SSI, SSDI, and Medicaid and suggests measures to ensure that eligible inmates with a psychiatric disorder receive health care or disability benefits upon their release.

A major section of the report helps readers negotiate complicated Medicaid rules and regulations.

"Federal Medicaid rules do not require the termination of inmates' Medicaid eligibility," Koyanagi told *Psychiatric News*. Those rules "only require that inmates' Medicaid coverage be suspended, not terminated. Suspension means that the inmates stay on the Medicaid rolls. . . but the jail or prison can not receive any reimbursements," said Koyanagi.

In practice, however, almost all states terminate inmates' Medicaid, according to a 2000 survey of Medicaid administrators

conducted by the Council of State Governments (CSG).

"Of the administrators from 49 states and four territories who responded, 46 wrote that they 'terminate' Medicaid when they learn a person has become an inmate. This means that the person is removed from the Medicaid rolls and has to complete a new application," said Michael Thompson, director of the criminal justice programs for the CSG's eastern regional conference, in an interview with *Psychiatric News*.

One typical scenario involves inmates who qualify for their Medicaid because they are eligible for SSI benefits. After incarceration for a full calendar month, their SSI is suspended. And when the state Medicaid office is notified of this suspension, it almost always terminates their Medicaid, as the CSG study indicated, said Koyanagi.

Often, however, "inmates' Medicaid is terminated even when the inmate is incarcerated less than 30 days and has not been convicted," according to Collie Brown, senior director of the National Mental Health Association's Criminal Justice Programs, and Henry Steadman, Ph.D., president of Policy Research Associates, which works nationally to improve services for inmates with co-occurring mental health and substance abuse disorders.

Effects of Medicaid Termination

"When Medicaid is terminated for inmates whose Medicaid eligibility is not tied to SSI, they can't get access to needed mental health

services until the Medicaid agency finds them eligible under another program or they successfully reapply," said Lee Carty, the Bazelon Center's communications director.

"If 'suspension' status would result in the person remaining on the Medicaid rolls and is accompanied by a simple procedure to remove the suspension upon verification of release from jail, that would be advantageous because it often takes several weeks before a former inmate is restored to the Medicaid rolls," said Mark Binkley, J.D., general counsel for the South Carolina Department of Mental Health, in an interview with *Psychiatric News*.

"If these agencies shared information on the Internet, so that data were transferred instantaneously, this would also help solve a lot of the problem," added Binkley, noting that most Social Security and Medicaid offices share information by exchanging electronic tapes weekly or monthly.

Medicaid Redetermination

The Bazelon Center report also discussed redetermination of Medicaid eligibility. "State Medicaid offices ought to be redetermining Medicaid eligibility for anyone who entered jail on Medicaid," said Koyanagi.

Regarding redetermination, former Health and Human Services Secretary Donna Shalala wrote in an April 6, 2000, letter to Congressman Charles Rangel that, "The state must ensure that the incarcerated individual is returned to the [Medicaid] rolls immediately upon release, unless the state has determined that the individual is not eligible for some other reason."

"If this redetermination were done, most inmates entering with Medicaid would still be eligible when released, since their income in jail almost never increases," said Koyanagi.

"But we know this redetermination is not being done because individuals with serious mental illness almost invariably leave jail with no Medicaid," she said.

Begin Process Sooner

When asked why some states terminate rather than suspend Medicaid eligibility, Thomas Shenk, health insurance specialist in the Center for Medicaid and State Operations at the Center for Medicare and Medicaid Services (CMS) (formerly known

as the Health Care Financing Administration) said, "Some states may not have a system in place for suspending eligibility. And still other states may terminate Medicaid to ensure that no Medicaid claims are filed by inmates."

Regarding redetermination, "Generally, the redetermination process begins after inmates are released, and we don't have the authority to make states begin this process sooner, while they are still in jail," Shenk said. "CMS agrees with Bazelon that there needs to be a mechanism or procedure to ensure Medicaid-eligible inmates receive Medicaid upon release."

"CMS is well aware of this problem of inmates being released without their Medicaid eligibility being established or reestab-

"Individuals with serious mental illness almost invariably leave jail with no Medicaid."

lished and is in the process of developing a letter to state Medicaid directors addressing this concern."

SSI and SSDI

The Bazelon Center "does not take issue with [the Social Security Administration] for stopping payment of cash SSI or SSDI benefits when an individual is an inmate in a correctional facility. . . . We do, however, object to the fact that most of the time SSI or SSDI eligibility is not reinstated upon the inmate's release," said Koyanagi.

To remedy this situation, the report suggests that jail employees or employees from the local SSA, Medicaid office, or community mental health agency assist individuals in applying or reapplying for SSI, SSDI, and Medicaid while they are incarcerated. "And if in-person interviews are required, jail personnel could accompany inmates," said Carty.

Stephen Ingley, executive director of the American Jail Association, said, "I believe jail personnel would support these initiatives if given the resources necessary to make such a program work, while maintaining a safe and secure operation."

Koyanagi's report for the Bazelon Center is available on the Web at <www.bazelon.org/findingthekey.html> ■

Prerelease Preparations Crucial

The Bazelon Center's report on mentally ill jail inmates and Medicaid eligibility explains the Social Security Administration (SSA) program in which officials from jails and prisons (or any other institution) enter into a formal written or informal prerelease agreement with the local SSA office.

"In the prerelease agreement program, we get the Supplemental Security Income (SSI) application process going before inmates are released," said Mark Hinkle, spokesperson for SSA. He noted that the program began in 1974 when SSI began.

"Local SSA employees train the jail's case workers and social workers to identify inmates who may be eligible for SSI. This may include inmates whose SSI has been suspended or terminated as well as those applying for the first time.

"SSA employees review paperwork and have appropriate forms completed. In some situations, jail staff may help with the paperwork. The paperwork process typically begins 30 days before the inmate's release," said Hinkle. "[Then] the SSA office processes applications from these jails as quickly as possible, so inmates can have benefits upon their release," Hinkle explained.

"For inmates whose SSI has been suspended, most of the forms can be filled out in the jail, and these individuals only need to complete a simple procedure upon their release," said Hinkle.

However, "for inmates who have to re-initiate the entire SSI application process, this can take several months to over a year, if a hearing or further appeals are required," according to Barbara Silverstone, staff attorney at the National Organization of Social Security Claimants' Representatives.

When asked if this process would start earlier than 30 days before release for these inmates, Hinkle replied, "In some situations it can, and in others it can not, but at least we can get the process started."

Although SSA does not have data on how many jails are taking advantage of the prerelease program, Steadman and Brown said that "prerelease agreement programs in jails are very rare."

Information on the SSA's prerelease program is available on the Web at <www.ssa.gov/notices/supplemental-security-income/spot-prerelease.htm>.

Medication Order

continued from page 2

case and an earlier landmark case concerning forcible medication shows considerable change in both judicial attitudes and the efficacy of antipsychotic medication.

In 1992, the U.S. Supreme Court reversed the death penalty conviction of David Riggins in the case *Riggins v. Nevada*, holding that the due process clause of the 14th Amendment offered defendants awaiting trial a qualified right to refuse treatment. Riggins had received an involuntary, daily dose of 800 milligrams of Mellaril during the trial.

The Supreme Court in that case was concerned about the side effects of antipsychotic medications. "While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects." Although the ruling held that the administration of Mellaril

was "medically appropriate," the justices also noted that the medication may have impacted [Riggins'] "testimony's content, his ability to follow the proceedings, or the substance of his communication with counsel."

In a separate concurring opinion, Justice Anthony Kennedy wrote, "The medical and pharmacological data in the amicus briefs and other sources indicate that involuntary medication with antipsychotic drugs poses a serious threat to a defendant's right to a fair trial."

The Weston case might also be headed to the Supreme Court as well. The head of Weston's defense team, A.J. Kramer, said he was almost certain to appeal the ruling, either to the full appeals court or the U.S. Supreme Court. Appelbaum said, "Although it's likely that the decision will be appealed, the opinion from the D.C. Circuit provides a sound basis on which further appellate decisions can be grounded." ■

Don't Ignore Medicaid in Lobbying Efforts, Advocates Warned

Medicaid has become a 1,000-pound gorilla for anyone concerned about the public mental health system.

BY KATE MULLIGAN

Advocates for public mental health services must pay more attention to Medicaid. That was the blunt message delivered at the June National Mental Health Association Conference (NMHA) by two experts on the subject.

"Medicaid is becoming the primary source of funds for public mental health services," said Jeffrey Buck, Ph.D., associate director for organization and financing at the federal Center for Mental Health Services (CMHS). "In 1987 funds from that program represented less than 40 percent of total public mental health funding. If current trends continue, that figure will climb to more than 60 percent by 2012."

David Nelson, the NMHA's vice president of health care reform, said, "Advocates have learned how to influence state mental health bureaucracies, but they have not always developed strong relationships with Medicaid agencies. A new advocacy role will become particularly important in times of budget deficits."

John J. Wernert III, M.D., the Indiana Psychiatric Society's (IPS) deputy repre-

sentative to the APA Assembly, and other IPS members developed valuable experience with that new role when budget deficits threatened the pharmacy benefit to Medicaid recipients. As the governor's appointee to the Indiana Medicaid Drug Utilization Review (DUR) Board (DUR), Wernert had an early warning about possible changes in the benefit.

"As is true in most states, the pharmaceutical costs to the Medicaid program have skyrocketed," Wernert told *Psychiatric News*. "The DUR board was required by the governor's office to cut over \$80 million from the pharmacy benefit. Prior authorization became the method of choice to achieve those cost savings."

Wernert and others were concerned that prior authorization strategies would be used on an "experimental" basis on psychotropic drugs. He believes that because of their high cost, psychotropic medications will always be a potential target of cost-cutting measures in state Medicaid programs.

As chair of the board of the Mental Health Association of Indiana, Wernert was in a good position to help build a broad coalition of organizations that have an in-

terest in protecting access to psychotropic drugs. He and IPS legislative representative Stephen R. Dunlop, M.D., worked closely with Beth Karnes, president and chief financial officer of the Indiana Mental Health Memorial Foundation, to identify allies. In addition to the IPS, the coalition ultimately included consumer groups, family members, psychiatric nurses, psychologists, and other advocates.

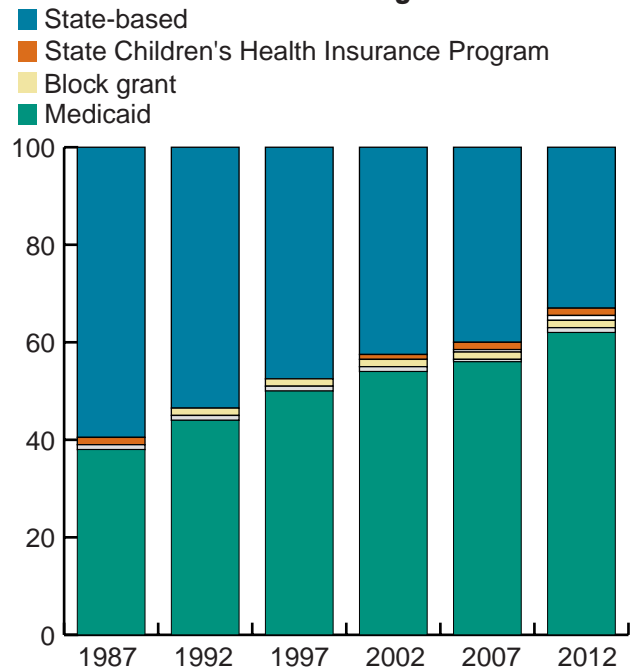
Wernert said, "The professional and pharmaceutical industries will usually appear self-serving when they complain about prior authorization for restrictive practices relating to pharmaceuticals. Yet, when advocacy groups such as the Alliance for the Mentally Ill and the Mental Health Association use their grass-roots supporters, the legislators take notice."

Coalition members also developed a broad approach to their advocacy. In a telephone interview, Karnes said, "Our strategy involved a four-pronged approach at the state level. Instead of merely focusing on key legislators and the governor, we targeted the state Medicaid and budget office as well. We made the argument to the Medicaid

staff that the *Olmstead decision* [which requires that persons with mental illness be treated in the least-restrictive setting] would be difficult to implement without access to appropriate medication."

He continued, "We encouraged the state budget office to look at the big picture."

State-Level MH Financing Trends



Source: CMHS, SAMHSA

The percentage of the public mental health dollar that comes from Medicaid is steadily rising at the state level.

Members of the coalition presented study findings showing that cost savings result—see *Medicaid* on page 27

Strict U.S. Alcohol Laws Reduce Teen Drinking, Study Suggests

With the release of two related studies, the federal government presents a profile of the consequences of illicit drug and alcohol use among Americans and, for the first time, compares those data with European statistics.

BY JIM ROSACK

Few seem to dispute that illicit drug and alcohol use has soared over the last decade nor that the consequences of that use have also continued to multiply. However, as addiction specialists and lawmakers ponder the latest data on those consequences, an interesting finding has emerged.

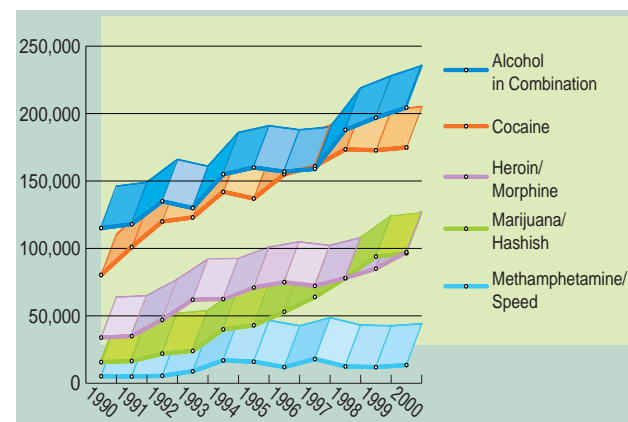
Contrary to some long-held beliefs, the stricter control of alcoholic beverages in the United States has not translated into a “forbidden fruit” mentality where American youth drink more and experience more problems than countries with weaker controls on alcohol sales and consumption.

According to a new study by the U. S.

Department of Justice’s Office of Justice Programs (OJP), the first direct comparison of data on drinking rates of European and U.S. youth showed that young people in the U.S. fare better on three common measures of problematic drinking (see chart on page 1).

In recent years European countries have sometimes been cited as an example in the argument to loosen restrictions the United States imposes on the sale and consumption of alcohol. Proponents of loosening restrictions claim that

Drug-Related Emergency Room Visits, By Selected Drug: 1990-2000



Source: U.S. Department of Justice, Office of Justice Programs

The number of drug-related ER visits rose dramatically for each illicit drug followed through the 1990s. Data are from the 2000 DAWN study.

doing so would reduce the appeal of the “forbidden” substance and thus translate into reductions in underage drinking and its consequences. They claim that because of looser controls in most countries in Europe, European youth “grow up around alcohol” and therefore learn to drink more responsibly at earlier ages than do American youth.

Not so, according to the data released by the justice department. The OJP comparison looked at data collected in 1995 from the European School Survey Project on Alcohol and Other Drugs (ESPAD), which targeted 15- to 16-year-old students in 26 European countries.

The questionnaire used in the European study was closely modeled after the Monitoring the Future Survey (MTF), con-

“We need to reach out to people before they become statistics in emergency departments—or worse, in the morgue.”

ducted for the National Institute on Drug Abuse since 1975.

The European data were compared with the MTF data collected from more than 17,000 10th-grade students in 1995. In the MTF survey, 39 percent of 10th graders reported that they had drunk alcohol in the preceding 30 days. With the exception of Croatia, which tied with the U.S. at 39 percent, each of the remaining European countries had higher rates of drinking within the previous 30 days.

Both the ESPAD and MTF surveys also looked at binge drinking, defined as consuming five or more drinks in a row. Only Portugal (14 percent) had a substantially lower rate than that seen in the U.S. (24 percent).

A third measure of potentially problematic youth drinking analyzed by the OJP was intoxication.

Both the ESPAD and MTF used identical questions on the surveys to identify self-reported incidents of intoxication within the previous 30 days. On this measure, adolescents in the U.S. showed a moderate rate of intoxication (21 percent) compared with their European peers. Some countries (Greece, Portugal, Croatia) had lower rates of self-reported youth intoxication, while others (Denmark, United Kingdom) had higher rates.

The Justice Department study concludes *see Alcohol Use on page 32*

Satcher Sounds Alarm Over Mental Illness Impact

The world's largest mental health advocacy group convenes an impressive roster of speakers to call attention to the global impact of mental illness.

According to U.S. Surgeon General David Satcher, M.D., the first Surgeon General's Report on Mental Health, released in 1999, was not just part of a national strategy, but a global one to improve mental health worldwide.

Satcher emphasized this point at the international plenary session of the National Alliance for the Mentally Ill's (NAMI) 2001 Annual Convention in Washington D.C., in July.

He was speaking about a May summit of members from the World Health Assembly, who met in Geneva, Switzerland, to discuss mental health. "People from all over the world met to discuss mental health, and our report was part of that discussion," said Satcher.

"Mental health should be supported and invested in to the same extent that we support other aspects of health," said Satcher, who spoke to a room packed with hundreds of mental health advocates and professionals.

NAMI members from around the world, including people with mental illness, family members, and mental health professionals—as well as 100 delegates from 23 countries—gathered to hear Satcher and other panelists speak about the global im-



Photo: Mike Ciesielski

U.S. Surgeon General David Satcher, M.D.: "Mental health should be supported and invested in to the same extent that we support other aspects of health."

pact of mental illness.

Addressing the international theme of the plenary session, Satcher told NAMI members that worldwide about 400 million people live with psychiatric or neurological disorders, including drug and alcohol abuse.

"Globally, unipolar major depression ranks fourth in disability disease burden," said Satcher. But the news got worse. "We project that by 2020, it will rank second only to heart disease."

Satcher also spoke out against the ever-
see Satcher on page 32

Nurse Battles To Erase Korea's Entrenched Stigma Problem

Thanks to the hard work and determination of Susie Kim, D.N.Sc., people living with mental illness in South Korea have a better chance of recovering successfully.

In Korea, stigma keeps people with mental illness behind closed doors, quite literally. But this proved no obstacle to Susie Kim, D.N.Sc., who strove to get treatment to those who needed it.

Kim traveled from Korea to speak on a

Photo: Mike Ciesielski



Susie Kim, D.N.Sc. "In many societies, people with mental illness have been excluded from their communities."

panel at the international plenary at the National Alliance for the Mentally Ill (NAMI), 2001 convention in July.

Kim, who is director of the Research Institute of Nursing Science and chair of the Psychiatric Mental Health Nursing Division at Ewha Women's

University also identifies herself as a psychiatric nurse, an advocate, and family member of someone with mental illness.

Her favorite cousin, a naval academy graduate, was diagnosed with schizophrenia at the age of 29.

In 1992, when she was dean of the College of Nursing Science at Ewha Women's University in Seoul, Korea, Kim helped to establish the first training program for psychiatric mental health nurse practitioners in the country.

see Kim on page 32

Anosognosia Keeps Patients From Realizing They're Ill

A growing body of evidence points to the fact that for many people with serious mental illness, lack of insight is a medically based condition.

About half of the people with schizophrenia and bipolar disorder may not be getting the treatment they need because of a brain deficit that renders them unable to perceive that they are ill, according to one expert.

Anosognosia, meaning “unawareness of illness,” is a syndrome commonly seen in people with serious mental illness and some neurological disorders, according to Xavier Amador, Ph.D., who spoke at the 2001 convention of the National Alliance for the Mentally Ill in Washington, D.C., in July.

People with this syndrome do not believe they are ill despite evidence to the contrary, said Amador, who is director of psychology at the New York State Psychiatric Institute and professor of psychology in the department of psychiatry at Columbia University College of Physicians and Surgeons.

“People will come up with illogical and even bizarre explanations for symptoms and life circumstances stemming from their illness,” he said, “along with a compulsion to prove to others that they are not ill, despite negative consequences associated with doing so.”

Take Theodore Kaczynski, for example. Kaczynski, otherwise known as the unabomber, rejected claims that he was mentally ill even though it could have cost him his life.

At one point during his 1997 trial, Amador explained, Kaczynski, who stood accused of killing three people and injuring 23 with his homemade bombs, refused to be examined by state psychiatric experts. Although a mental illness defense was his only hope of escaping a first-degree murder conviction and a possible death sentence, he blocked his attorneys from using the insanity defense.

Amador, who served as an independent expert for the court, reviewed Kaczynski’s extensive psychiatric records, neuropsychological test results, and the infamous unabomber diaries. Amador then supplied the court with mounting evidence that Kaczynski’s refusal to be evaluated related to anosognosia, a manifestation of Kaczynski’s schizophrenia.

Amador’s quest to understand the basis of this syndrome lies a little closer to home.

It was his experience as a clinician and as a brother of someone with schizophrenia, Amador said, that led him to do research on anosognosia, “which is not to be confused with denial,” he emphasized, although in the beginning, he did not make that distinction.

“That’s what I called it when my brother refused to take his medications, and that is what I called it when after his third hospitalization, I found his Haldol in the trashcan,” said Amador.

“This is someone who taught me to throw a baseball and ride a bicycle. I really looked up to him and was appalled by what I thought was his immaturity, stubbornness, and defensiveness.”

But research points to a much more complex problem.

Intrigued by a 1986 study by William

H. Wilson, M.D., and colleagues that found that 89 percent of patients with schizophrenia denied having an illness, Amador conducted his own investigation of the issue.

Amador and his colleagues found in a 1994 study that nearly 60 percent of a sample of 221 patients with schizophrenia did not believe they were ill.

A Frustrating Existence

Amador also described what it is like to work with someone who has anosognosia.

One patient encountered by Amador had a lesion on the frontal lobe of his brain. He was unaware that he was paralyzed on his left side or that he had problems writing. When asked to draw a clock, the patient thought he did fine, Amador recalled.

However, when Amador pointed out to the patient that the numbers were outside of the circle, the patient became upset. “The more I talked to him [about the drawing], the more flustered he got. . . . Then he got angry and pushed the paper away, saying ‘it’s not mine—it’s not my drawing.’ ”

Amador finds the same reaction appears



Xavier Amador, Ph.D.: “People will come up with illogical and even bizarre explanations for symptoms and life circumstances stemming from their illness.”

when he talks to people with severe mental illness, which sometimes involves similar frontal lobe deficits. “Instead of being an ally, I end up being an adversary,” he said.

Building Trust

Amador urged family members and mental health professionals at the NAMI meeting to understand that collaboration with treatment by someone who has a severe mental illness and anosognosia is

a goal, not a given.

see *Anosognosia* on page 32

Committing a Loved One Can Be the Best Medicine

When planned ahead of time, commitment can be an empowering process for people with mental illness, advocates maintain.

BY EVE KUPERSANIN

Hindsight is always 20/20, according to an old adage. Anna-Lisa Johanson now knows that committing a loved one with mental illness can be a lifesaving act inspired by love—but she learned this lesson the hard way.

Johanson's mother made headlines when she took her own life at the age of 46 by kneeling before a speeding train in October

1998. In her lifetime, Mary Margaret Ray gained notoriety in the media because of her bizarre delusional behavior and stalking of comedian David Letterman. Ray was diagnosed with schizophrenia and schizoaffective disorder.

"I lost my mother because I didn't know how to commit her," Johanson told a room of mental health professionals, family members, and people with mental illness at the 2001

convention of the National Alliance for the Mentally Ill (NAMI) in Washington D.C., in July. The only psychiatric treatment her mother received was through the criminal justice system during repeated incarcerations, she noted.

Now, however, Johanson is well on her way to becoming an expert in commitment law.

Johanson is finishing a joint program in law and public health at Georgetown University and Johns Hopkins University and is interested in pursuing a career in mental health advocacy.

She also has a new daughter and works part time at the Treatment Advocacy Center (TAC) in Arlington, Va., where she helps people with mental illness and their family members understand commitment laws.

TAC is a nonprofit advocacy organi-

zation dedicated to removing legal and clinical barriers to psychiatric treatment for people with severe mental illness.

Johanson also co-authored the book *I Am Not Sick, I Don't Need Help: Helping the Seriously Mentally Ill Accept Treatment* with Xavier Amador, Ph.D., published by Vida Press in 2000.

"My father is an old Swedish socialist," said Johanson. "The reason he never committed my mother was that no matter what, he would never violate her independence or her rights."

Johanson said that she grew up believing that personal freedom and self-determination were sacred. But now she thinks differently.

"There is a certain point where a brain disorder takes over, and you no longer possess free will—it has been obliterated because of a chemical imbalance," said Johanson.

After taking an informal poll of NAMI members in the room, Johanson found that many felt dread at the thought of committing a loved one, and many feared being committed themselves. Johanson empathized. "I suffer from bipolar disorder. It has never been far from my mind that a

"I lost my mother because I didn't know how to commit her."

week or two beyond medication and I could be at a point where my loved ones would have to commit me."

Johanson advised family members and people with mental illness to research the commitment process and have all the necessary steps taken care of ahead of time, so that the commitment process is less traumatic if it ever needs to be used.

For instance, people with mental illness can shop around for a psychiatrist they trust and can talk with openly. People can also call the emergency room or psychiatric unit of their local hospital and ask if they have a partnership with the police department, Johanson suggested.

She also said that it is useful for people to find out if the police department has an officer who is specially trained to work with people with mental illness, and if so, keep the number of that officer handy.

Beyond this, there is one crucial measure that people with mental illness should take. "See if your state has something called an advance directive for mental health care," said Johanson.

This is a legal document that allows people with mental illness to exert some control over the terms of their commitment prospectively through written instructions about psychiatric care. The advance directive also appoints an agent to ensure that the instructions are carried out (*Psychiatric News*, December 15, 2000).

This legal document is useful, Johanson emphasized, for people who may want to plan ahead for their own possible commitment.

In this scenario, someone might first choose a psychiatric hospital where he or she would prefer to be treated. Then, he or she can go with a loved one to an attorney and sign an advance directive specifying that if two doctors decide that he or she needs help, this is the person's hospital of choice.

"It is empowering to set up this safety net for yourself," Johanson emphasized.

see *Commitment* on page 15

NARSAD Awards Scientists For Research Advances

Groundbreaking research that is paving the way for better psychiatric treatments is recognized with awards for several scientists.

Advances in psychiatry are helping millions of people with mental illness to recover, and seven outstanding researchers can take some of the credit.

The National Alliance for Research on Schizophrenia and Depression (NARSAD) bestowed awards on seven researchers on July 27 in New York City at the Klerman and Freedman Awards Dinner.

Myrna Weissman, Ph.D., established the Klerman award in 1994 to honor her late husband, psychiatrist Gerald Klerman, M.D. Klerman was an educator and depression researcher at Yale University, Harvard University Medical School, and Cornell University. He also served as chief of the Alcohol, Drug Abuse, and Mental Health Administration under President Jimmy Carter.

NARSAD's board of directors established the Freedman awards in 1998 to honor the memory of Daniel X. Freedman, M.D., who became chair of psychiatry at the University of Chicago in 1966 and a few years later, chief editor of the *Archives of General Psychiatry*. In 1984, Freedman left Chicago to become professor of psychiatry and pharmacology at the University of California in Los Angeles. Freedman was also a president of APA.

NARSAD, sponsor of the awards, describes itself as the largest donor-supported organization in the world devoted exclusively to supporting scientific research on psychiatric disorders and has awarded over \$112 million in research grants to more than 1,300 scientists since its founding in 1986.

The seventh annual Gerald L. Klerman awards were presented to the following recipients, each of whom received \$1,000:

- Cameron Carter, M.D., associate professor in the department of psychiatry at the University of Pittsburgh. Carter researched the neurological basis of problems with attention in schizophrenia and used magnetic resonance imaging to study attentional dysfunction. He found that the

anterior cingulate cortex was least active when attention was strongly engaged and most active when it was weakly engaged and performance was poor, indicating that this part of the brain regulates attention by monitoring performance and detecting processing conflicts.

- Joseph Hibbeln, M.D., a psychiatrist and chief of outpatient research in the Laboratory of Membrane Biochemistry and Biophysics at the National Institute of Alcohol Abuse and Alcoholism of the National Institutes of Health. Hibbeln studied the role of omega-3 essential fatty acids, often found in seafood, in a number of psychiatric disorders. Hibbeln and colleagues examined the prevalence of bipolar disorder and schizophrenia in 15 countries and found that greater seafood consumption lowered lifetime prevalence rates of bipolar disorder—but not schizophrenia or anxiety disorders.

"I am honored and grateful to receive the Klerman award from NARSAD," said Hibbeln. "This award is especially meaningful to me because my initial hypothesis in this field linked Dr. Klerman's data on the increasing prevalence rates of depression to the dietary changes of omega-3 fatty acids during the last century."

- Sarah Lisanby, M.D., an assistant professor of clinical psychiatry and director of the Magnetic Brain Stimulation Lab at Columbia University. She has investigated repetitive transcranial magnetic stimulation (rTMS) to study the neural systems regulating mood and in the treatment of major depression. Lisanby and her research team were the first to demonstrate the feasibility of using this treatment for depression. Lisanby expressed "a great debt of gratitude to the people with depression who volunteered for my studies with transcranial magnetic stimulation."

- Perry Renshaw, M.D., Ph.D., associate professor of psychiatry at Harvard University Medical School and director of the Brain Imaging Center at McLean Hospital. Renshaw studied the use of proton magnetic resonance spectroscopy, a new form of low magnetic field stimulation, to guide de-

see *Awards* on page 32



Recipients of the Klerman and Freedman awards pose after receiving their awards on July 27 at an awards dinner in New York: (left to right) Klerman awardees: Perry Renshaw, M.D., Ph.D.; Cameron Carter, M.D.; Joseph Hibbeln, M.D.; and Sarah Lisanby, M.D. Freedman awardees: Michael Caterina, M.D., Ph.D.; Kelsey Martin, M.D., Ph.D.; and Aurelio Galli, Ph.D.

Journalist Pulls Back Curtain of Psychiatric ER

How did psychiatry come to get such excellent billing on the front page of a big-city newspaper? This is the story behind the APA-award-winning article, which involved not just a dedicated journalist but a dedicated child psychiatry fellow.

BY JOAN AREHART-TREICHEL

Each year, APA bestows an award on a newspaper reporter who has done an outstanding job covering issues in psychiatry. The recipient this year is a soft-spoken reporter from the *Baltimore Sun* named Diana Sugg.

APA gave her its Robert T. Morse Award for an article titled “A Hospital Crisis: Children in Need of Psychiatric Care.”

Nada Stotland, M.D., speaker of the APA Assembly, was very impressed with Sugg’s efforts. As Stotland told *Psychiatric News*, “She has done an extraordinary front-page story based on following a child psychiatry fellow at Johns Hopkins throughout emergency calls and putting heart-rending faces” on children who do not get mental health care elsewhere.

How the article came to be, however, is a story in itself. It involved not only Sugg but psychiatrists at Johns Hopkins, and especially the child psychiatry fellow Irm Raja Bellavia, M.D. In a sense, the article was a collaboration between Sugg and Bellavia, and this collaboration affected each of them, both professionally and personally. Here, then, is the story behind the story.

In spring 1999, a Johns Hopkins press-relations representative called Sugg to say that the number of youngsters with mental health problems showing up at the Johns Hopkins Children Center emergency room had increased dramatically since 1995, and that she thought that there might be a news story for Sugg in the increase. “That was it basically, one phone call, saying these kids are flooding the emergency room,” Sugg told *Psychiatric News* during a phone interview.

At first Sugg thought it would be a straightforward news story—maybe a mental health clinic near Johns Hopkins had closed, leading to an overflow of mental health patients at the Hopkins emergency room. But as she got things underway, she started to suspect that the causes were much more complex. Even more disturbing, she hypothesized, was that what was happening at Hopkins might be occurring in other hospital emergency rooms around the United States. In other words, it was looking as if there might not be enough mental health services for young people, so that they resorted to visiting emergency rooms for their problems.

Sugg was convinced that in order to do justice to this complex subject and give it a human angle, she needed to get inside Hopkins’ emergency room and witness firsthand what was happening.

“But there were two problems,” she explained. “First, we are talking about kids. Secondly, we are talking about psychiatric care. And both are often confidential arenas. So it ended up being a series of meetings between me and some of the psychiatrists who were overseeing the care of these kids in the emergency room, telling them who I was and what I wanted to do. Getting them to trust me. This went on for a few months. It wasn’t like it was every day,

but rather a continual push to get into the emergency room. Finally, in fall 1999, they said, ‘Okay, you can go in and follow one of our residents for one night.’ “

That resident was Bellavia. She had just started her fellowship in child and adolescent psychiatry at Hopkins, and her training director asked her if she would be willing to work with Sugg. She said yes.

“At first I was just like anyone would be,” Bellavia said during a phone interview from her home in Charlotte, N.C. “You feel a bit more self-conscious about your abilities and kind of feel that you are being watched. But Diana was so natural and so cooperative, and I was so busy that after a while I sort of forgot that she was there.”

Families’ Response

Tagging along with Bellavia, however, turned out to be more challenging for Sugg. For instance, even though Bellavia would explain to families what Sugg was doing and ask whether it was all right if Sugg sat in during their medical visits, Sugg gathered pretty quickly that many families were in

“I think the article made me more appreciative of the power of the media and how it can impact child psychiatry issues.”

crisis and couldn’t decide at that point whether they wanted to be included in a newspaper article. So Sugg would say to them, “I would like to sit in and take notes and see what’s happening and chat with you, but I guarantee you that none of this is going to be in the paper unless later, when I contact you, you agree to it. In other words, they didn’t have to make a decision that night, but I was still gathering potential information for my article.”

On still other occasions, families would appear to feel comfortable about Sugg sitting in during their medical visits, yet she wasn’t comfortable about it.

For instance, she said, “there was a boy of 13 or so with his mom, and one of the questions was, ‘Are you sexually active?’ And I thought, I don’t think it is right that I am sitting in on this. Yet, on the other hand, I was thinking, I can really help educate the public, get them to understand what these kids are going through, that these [psychiatric disorders] are medical illnesses that can be treated.”

Psychological Toll

Just being in the emergency room with so many mentally ill children and their distressed families took its psychological toll on Sugg. “It was very disturbing to see kids in such pain,” she said. “There was a 3-year-old boy who had tried to kill himself and his younger brother. There was a 14-year-old boy kicking his feet against the exam table, upset about his parents’ divorce. He was kind of shy, looked up at Dr. Bellavia,

Photo by The Baltimore Sun staff photographer Kenneth K. Lam and reprinted with permission of The Baltimore Sun



Irm Raja Bellavia, M.D., tries to find a bed for a patient arriving at Johns Hopkins’ emergency room at 2 a.m.

and asked, ‘Can I just come here once and a while and talk with you?’.”

Nonetheless, Bellavia and Sugg got through their one-night collaboration, and what had started off as just a one-night affair actually turned into a seven-night one. “I had to cover my regular health-and-medicine beat at the *Baltimore Sun* at the same time,” Sugg explained, “so it would be like one night a week at the emergency room as well. I would just go in there prepared, wearing comfortable clothes, carrying my tape recorder, tapes, water, and crackers. Time was on my side for observing and talking with families because they had to wait so long for their children to receive medical attention.”

Also, as these seven nights went by, Sugg came to better understand psychiatry and to hold psychiatrists in higher esteem. “It gave me an appreciation of how complicated, how deep psychiatry is,” she said. “And Dr. Bellavia was wonderful! She would be so busy sometimes at three in the morning, doing paperwork and trying to get these kids admitted, and I could see that these families were haunting her, too.”

Also, as the seven nights went by, Bellavia came to acquire a better understanding of journalism and to acquire a greater respect for journalists. “Diana would be in the background and sometimes even talk with the families,” Bellavia said. “And sometimes it was helpful to have her there, she is very sensitive.”

Response to Article

But perhaps the biggest rewards accruing from their collaboration emerged after Sugg’s article about it was published on Sunday, February 13, 2000.

On a light note, for example, Bellavia and her husband went out for coffee and donuts in Baltimore that morning, and Bellavia was amazed to find not only Sugg’s article, but a photo of herself on the front page. During the next few days, Bellavia’s colleagues teased her about being a star.

On a more serious note, however, Bellavia said, “I think the article made me more appreciative of the power of the media and how it can impact child psychiatry issues. I was skeptical at first as to how much of my experience with Diana was going to be portrayed as truthfully and as sensitively as I would like. But after seeing the article, I acquired a new respect for journalism and especially for journalists like Diana who write about serious issues that need national attention.

“Local television stations also followed up on the article,” Bellavia continued.

“There was discussion about the need for more services for children with mental health issues. I think the article also received national recognition, and that was worthwhile, given that the problem in Baltimore sort of represents a microcosm of the experience in the country.”

And Sugg will never forget the phone call informing her that she had won an APA award for her article. “I had some health problems,” she said, “so when I got the call, it made me feel really good. Also, because top people in the country had looked at my efforts and had judged them as excellent, it helped me believe in myself again.”

So now that all is said and done, would Bellavia once again participate in a similar venture? “Yes, I definitely would,” she said. “If what I do not only helps my patients and their families, but also educates the public about the lack of mental health services for kids or about other child psychiatry problems, yes, I would do it, absolutely!”

And as for Sugg, would she undertake another investigation like the one at Hopkins? The answer is yes. In fact, she is already at work on another child psychiatry piece—this time about depression and suicide in youngsters. “The emergency room story was well-received in the community,” she said. “People found it moving, people thought I got it right, so they are now entrusting me with personal experiences for this article as well.”

Sugg’s award-winning article, “A Hospital Crisis: Children in Need of Psychiatric Care,” can be read on a Baltimore Sun Web site at <www.sunspot.net/search> for a fee of \$1.95. ■

professional news

Commitment

continued from page 13

As of last count, 13 states recognize psychiatric advance directives, according to Bob Fleishner, J.D., who is an attorney at the Center for Public Representation in Northampton, Mass. Fleishner said that all states do have general advance directive laws that allow for instructions for mental health care, however.

“It is a little late now, but had I been able to, I would have committed my mother,” said Johanson. “It would have been the greatest service to her, and she would be here today to meet her granddaughter.” ■

APA Hires Medical Editor For Practice Guidelines

New York psychiatrist Laura Fochtmann, M.D., joins the APA staff in the new position of medical editor of the practice guideline program.

APA has hired Laura Fochtmann, M.D., an associate professor of psychiatry and of pharmacological sciences at the State University of New York at Stony Brook, to fill the newly created position of medical editor for its practice guidelines program.

As the medical editor, which is a half-time position, Fochtmann will play a major role in coordinating the development of future practice guidelines in the popular series and in revising existing guidelines.

Fochtmann, who began her new duties on July 2, told *Psychiatric News* that two major components of her job will be to work with the APA Steering Committee on Practice Guidelines, chaired by John McIntyre, M.D., in the selection of topics to add to the guideline series and with the expert work groups that develop and revise each of the practice guidelines.

She added that her collaboration with the expert work groups will involve participating in the extensive literature reviews



Laura Fochtmann, M.D., is the new medical editor for APA's practice guideline program.

that form the basis for developing the guidelines, in assessments of the importance of specific topic areas, and in discussions of the quality of the evidence on each topic being evaluated. "I will also work on integrating and processing the comments and reviews that come from the many experts not on the work groups to whom

drafts of the guidelines are circulated," Fochtmann said.

"In addition, I will help ensure that there is a consistent writing style for each section of a practice guideline," she said.

In her new APA role Fochtmann will report to Lloyd Sederer, M.D., director of the Division of Clinical Services, who oversees all phases of the practice guideline project.

Fochtmann received her undergraduate degree in electrical engineering with a concentration in biomedical engineering before attending medical school at Washington University in St.

Louis. After her psychiatry residency she completed a clinical psychopharmacology fellowship at the National Institute of Mental Health where, she noted, she "gained insight into formal data analysis and integrating research findings with clinical practice," expertise that should prove valuable in her new APA role. She has also been a representative from the Greater Long Island Psychiatric Society to the APA Assembly and a member of the APA Committee on Electroconvulsive Therapy.

Fochtmann commented that she is "excited about the opportunity to work with members of the work groups, the steering committee, and the uniformly superb APA staff that works on the practice guidelines,

and particularly to be able to do something of value for both psychiatrists and patients."

Following the Board of Trustees' approval in June of the practice guideline on borderline personality disorder (*Psychiatric News*, August 3), the next new guideline in the series will be one focusing on suicidal behaviors, with publication targeted for 2003. A revision of the bipolar disorder guideline, originally published in 1994, is also underway and follows revisions of the major depressive and eating disorders guidelines, which were released last year.

APA's practice guidelines are available on the Internet at <www.psych.org> by selecting the Clinical Resources site and clicking on Practice Guidelines. ■

Trustees Approve Principles For End-of-Life Care

APA has joined a number of other medical specialties in endorsing core principles for the care of patients at the end of life.

BY JOAN AREHART-TREICHEL

APA has joined the American Medical Association, the Academy of Psychosomatic Medicine, the American Pain Society, and other medical organizations in adopting core principles for the care of patients toward the end of their lives. The APA Board of Trustees endorsed the principles at its meeting in late June.

The principles concern such matters as respecting the dignity of both the patient and caregivers; being sensitive to and respectful of a patient's and a family's wishes; using the most appropriate measures that are consistent with a patient's choices; alleviating pain and other physical symptoms; assessing and managing psychological, social, and spiritual difficulties; letting the patient continue to be cared for, if so desired, by his or her primary care and specialist providers; providing access to any therapy that may realistically be expected to improve a patient's quality of life, including alternative or nontraditional treatments; providing access to palliative and hospice care; respecting the patient's right to refuse treatment; respecting the physician's professional responsibility to discontinue some treatments when appropriate, with consideration for both the patient's and the family's preferences; and promoting clinical and evidence-based research on providing care at the end of life.

Mary Ellen Foti, M.D., medical director of the Massachusetts Department of Mental Health, a member of APA's End-of-Life Committee, and liaison to the APA Assembly from the American Association of Psychiatric Administrators, was the APA member who introduced the proposal to adopt the end-of-life-care principles at the APA Assembly. Not surprisingly, she is pleased with APA's endorsement. "This is an area where psychiatrists have a tremendous amount to offer," she told *Psychiatric News*.

For instance, she pointed out, "There are many syndromal complexes that are really psychiatric that occur in this terminal phase of life. It is not just delirium, which is one of the common things that people see. You also see depression. You also see

tremendous anxiety. You see suicidal ideation. You see requests for euthanasia. There is a whole host of psychiatric issues that comes up."

And psychiatrists, she believes, should also get involved in research to improve end-of-life care for patients. She said that she and colleagues at the University of Massachusetts have a Robert Wood Johnson Foundation grant to enhance end-of-life care for persons with mental illnesses.

For example, they are attempting to

"This is an area where psychiatrists have a tremendous amount to offer."

learn whether mentally ill patients have end-of-life preferences similar to those of the general population. They have developed a tool that allows clinicians to assess a person's capacity to choose a health care proxy and are helping hospice workers feel more comfortable communicating with individuals who have serious mental illnesses, she said.

More information about the core principles for end-of-life care the Board endorsed and the medical specialties involved can be found on the Project on Death in America's Web site, <www.soros.org/death>. ■

New School Year Signals Start Of APA Alliance Essay Contest

Now that fall and another school year have started, so has another APA Alliance national "When Not to Keep a Secret" essay competition.

As in past years the arrival of autumn and a new school year signals that the APA Alliance's national high-school essay competition, "When Not to Keep a Secret," is again off and running.

This year's competition will be the fourth, and each year the competition seems to get bigger and better, thanks not only to the APA Alliance's hard work, but also to APA members' extensive support and gen-

erous funding by the American Psychiatric Foundation.

The kickoff of this year's competition includes a catchy poster that pictures winners of the last three national competitions and that gives details about this year's competition (see illustration). The poster will be sent to APA district branches, teachers, and other interested parties, such as the American Medical Association Alliance chapters.

Topics that essay competitors can write about this year have been broadened, so that they do not have to focus on teen depression and suicide, but can address any mental health issue that affects the lives of young people—say, eating disorders or relationship violence. Also, the competition continues to garner increasing recognition from the media, where radio and cable television programs cited the contest (*Psychiatric News*, July 6), and from educators. For instance, the San Diego Board of Education signed a resolution in August that recognizes the competition not only for its health and literary value, but for its civic value. "This was a big score for us," APA Alliance President Alicia Muñoz told *Psychiatric News*.

More information about this year's essay competition can be found on the APA Alliance's Web site at <www.apaalliance.org>. ■



Errata

Two APA members were erroneously listed in the "In Memoriam" column in the July 20 issue due to incorrect data given to *Psychiatric News*. They are Robert David Lerner, M.D., and Homer Chipman Curtis, M.D.

Also, a person was misidentified in a caption on page 11 of the July 20 issue. The person on the far left is Marian Fireman, M.D., not Carol North, M.D.

Psychiatric News apologizes for these errors. ■

Congress Addresses Bills With Mental Health Impact

While Congress was busy debating patient-protection bills, legislation was introduced that would ban employment discrimination on the basis of sexual orientation, expand stem cell research, and improve mental health services to rural areas.

BY CHRISTINE LEHMANN

Several bills have been introduced in Congress that could eventually have an impact on the mental health of Americans and on the care they receive.

Regarding stem-cell research, Sen. Arlen Specter (R-Pa.), ranking minority member of the Labor, Health and Human Services,

and Education Appropriations Subcommittee, praised President George W. Bush last month for his "very thoughtful analysis and decision to permit federal funding on some existing cell lines," according to a press release.

Specter added that he still plans to press for an early Senate vote on his bill (S 723)

when Congress returns from recess this month. His measure introduced in April, like the president's, would allow federal funding to go to research on stem cells extracted from extra frozen embryos in fertility clinics. The difference is that Specter's bill would not limit research to stem cell lines in existence prior to August 9, which is the date the president announced his decision.

"Our nine Appropriations Subcommittee hearings have demonstrated that more than 60 stem cell lines are necessary for scientific research to be done now and certainly in the future," said Specter. He added, "scientists should be given broad latitude, which should include federal funding to extract stem cells from embryos that are otherwise destined for destruction."

Specter said he would press for more committee hearings on stem cell research and human cloning this fall.

Kennedy, who chairs the Senate Health, Education, Labor, and Pensions (HELP) Committee, plans to hold a hearing this month on stem cell research and the implications of the president's decision. Specter's bill, which had 18 cosponsors at press time, was referred to Kennedy's HELP committee. The House companion bill (HR 2059) had 27 cosponsors at press time. APA has not taken a position on legislation involving stem cell research.

Rural Mental Health

In another legislative development, APA is supporting a bill in the Senate that would create several new programs to improve access to mental services in rural areas. The Rural Mental Health Accessibility Act (S 859), introduced by Sen. Craig Thomas (R-Wyo.) in May, would authorize several million dollars in grants to be awarded to eligible entities to:

- create community education programs to reduce the stigma and misinformation surrounding mental health,
- create interdisciplinary training programs in universities for providers of mental health care and primary care,
- study the effectiveness of mental health services delivered via telehealth technologies, and
- develop 20 demonstration projects to provide mental health services to children and the elderly.

APA's Division of Government Relations persuaded Thomas to drop family therapists and mental health counselors from the definition of mental health professionals in an earlier draft version. The bill now refers only to psychiatrists, clinical psychologists, clinical social workers, and clinical nurse specialists. The bill had eight cosponsors at press time.

Sexual Orientation Discrimination

Another bill Congress will consider would prohibit discrimination based on sexual orientation. This addresses an unfinished civil rights issue, emphasized Sen. Edward Kennedy (D-Mass.) in July when he reintroduced a bill that would bar employers from singling out gays, lesbians, and bisexuals for unfair treatment in the workplace. Rep. Christopher Shays (R-Conn.) introduced a companion measure in the House.

The bills would level the playing field for gays, lesbians, and bisexuals in the workplace by explicitly prohibiting employment discrimination against them. Sexual orientation is not a protected category under the employment discrimination section of the

see *New Bills* on page 33

MDs See Collective Bargaining As Weapon in Managed Care Battle

Psychiatrists struggle to level the playing field in their contract negotiations while steering clear of charges that they are restricting trade.

BY KATE MULLIGAN

Marc Rothman, M.D., president of the New Jersey Psychiatric Association (NJPA), said, "To paraphrase Benjamin Franklin, If we don't hang together, we will surely hang separately."

That philosophy is behind yet another effort to correct the imbalance of power between health professionals and managed care companies in contract negotiations. As part of that strategy, psychiatrists and other physicians in his state and in California are pushing legislation that would permit physicians and other health care professionals to bargain collectively with managed care companies.

California and New Jersey join Alaska, Connecticut, Florida, Illinois, Louisiana, Missouri, Montana, Pennsylvania, Rhode Island, and Tennessee, where so-called physician antitrust bills, which allow some form of collective bargaining, were introduced in the 2001 legislative session.

Negotiating problems are particularly acute in New Jersey where, according to Rothman, "Many psychiatrists are in small, individual practices. They don't even have the minimal clout of a psychiatrist in a large, multidisciplinary practice."

Clark Martin, the NJPA's public affairs counsel, added, "We've passed a patients' bill of rights and a prompt-payment bill, but we have to keep going back to the legislature every time we have a problem with managed care. Creating a mechanism so that doctors and managed care companies sit down together might be the answer."

The New Jersey bill (A 2169), known as the Joint Negotiations Legislation, would permit two or more psychiatrists to negotiate with a company about non-fee-related matters such as definition of medical necessity, utilization management criteria, the use of clinical practice guidelines, and patient referral standards and procedures.

Fee Negotiation Possible

If the attorney general found that an insurance or managed care company has substantial market power in its service area and that a managed care contract term poses a threat to the quality and availability of patient care, two or more psychiatrists would be able to negotiate about fee issues such as amount of payment, procedure codes, and amount of discount on the price of a health care or dental service.

No one could negotiate on behalf of psychiatrists without prior approval of the attorney general, who would consider factors such as the number of psychiatrists a negotiator represents and the ratio of those psychiatrists to the total number of psychiatrists practicing within a given geographic area. Negotiated contracts could not be implemented without the attorney general's approval, nor would any company be required to negotiate with representatives of health care professionals.

The bill was passed by the New Jersey Senate, reported out of the Assembly Health Committee, and will be considered in the next legislative session. Martin said, "If it passes, a veto by the governor is highly un-

likely. Acting Governor Donald DiFrancesco (R) was one of the bill's sponsors when he was in the state Senate."

California Legislation

Similar legislation in California received a boost with the recent release of a survey commissioned by the California Medical Association (CMA) to substantiate anecdotal evidence of recruiting problems and physician flight from the state and from medical practice because of managed care's interference and the increased costs to deliver high-quality care.

More than one-fourth of the responding physicians said they would no longer choose to practice medicine if they were starting over today.

California Assembly member Fred Keeley (D) first introduced AB 1600 in February. The bill would allow a group of health care professionals who have a contract with the same managed care company to negotiate with that company only when a contract is up for renewal or during the term of the contract if there is no provision for renewals. The bill covers physicians, nurses, psychologists, and other professionals. It includes provisions for facilitated negotiation and advisory arbitration. All negotiation would be voluntary by all potential parties.

As in New Jersey, the California government would have a strong role in determining appropriate representation. Before beginning negotiations, psychiatrists would be required to submit information about their numbers, licensure, and representation. The department could determine that the representation is not in the best interest of enrollees and recommend changes.

Any legislation that facilitates collective bargaining runs the risk of conflicting with the federal Sherman Antitrust Act, which is designed to prohibit agreements that restrict free trade and competition. Under the state-action immunity doctrine, however, activities allowed by individual states are exempt from federal antitrust prosecution if the state legislature sanctions the activities, and the state actively supervises them.

According to Fred Hellinger, Ph.D., senior economist at the Agency for Healthcare Research and Quality, and Gary J. Young, Ph.D., J.D., an associate professor at the Boston University School of Public Health, however, a change in the balance of power between health care professionals and managed care plans stands a better chance with passage of federal legislation than with state antitrust exemption legislation.

In an article titled "An Analysis of Physician Antitrust Legislation" in the July 4 *JAMA*, they report that the Quality Health Care Coalition Act (HR 1304), which passed the U.S. House of Representatives in 2000 and died in the Senate, "would have provided virtually all physicians an opportunity to join together to negotiate fees with managed care plans." Most state bills, however, limit approval of negotiations to physicians who are negotiating with plans with "substantial market power" and who constitute "no more than a small proportion (usually 10%) of the physicians in the relevant market." ■

Lawmakers Take Lunch Break To Learn About Mental Illness

The second in a series of Capitol Hill lunch briefings combined good food with stimulating talks on mental illness from the perspective of a psychiatric researcher, treating psychiatrist, and patient advocate.

BY CHRISTINE LEHMANN

Where do members of Congress and their aides and advisers go to learn about mental illness? Clearly, a source of useful information is the series of lunch sessions hosted by the House Working Group on Mental Illness.

The working group, cochaired by Reps.

Marge Roukema (R-N.J.) and Peter DeFazio (D-Ore.), was established in the 1990s and focuses attention on mental illness treatment and research. The group played an important role in passing the 1996 mental health parity law.

The group has 17 members and has sponsored several lunch briefings with logistical support from APA.

This year's series of three lunch briefings began in June (*Psychiatric News*, July 6) and ended in August.

They served up talks from leading psychiatric researchers, administrators of federal mental health agencies, and patient advocates.

The second briefing, which occurred in July, held the attention of congressional aides long after lunch was over. Psychiatrist Dennis Charney, M.D., who heads a federal anxiety and mood disorders program at the National Institute of Mental Health, sparked their interest when he looked at the group's youth-



Dennis Charney, M.D., chief of the mood and anxiety disorders research program at the National Institute of Mental Health, answers questions from congressional aides at a Capitol Hill lunch briefing in July.

ful faces and said they hadn't reached the average age of onset for depression, which is 35. But, he added, 20 percent of them were likely to develop some form of depression in their lifetime.

Charney said depression is the most serious of medical disorders because of its high mortality rate from suicide and its chronic, debilitating nature.

Untreated depression also affects the functioning of other systems in the body, he noted. "It alters people's immunity, which increases their risk of infectious diseases; reduces their metabolism of glucose, which increases their risk of diabetes; and affects the sympathetic nervous system, which increases the risk of cardiovascular disease," said Charney.

The good news, he pointed out, is that researchers are looking at the genetic and environmental causes of depression.

"The sequencing of the human genome is helping researchers identify the genes that predispose people to depression. I expect that in the next five to 10 years, we will be able to identify those genes and tell patients what their risk is. We will be able to discuss what kind of preventive measures make sense in terms of the environment and new medications," said Charney.

Neurochemicals

"We have discovered other neurochemicals involved in depression besides serotonin," said Charney.

He mentioned that corticotrophin releasing hormone (CRH) is associated with symptoms of anxiety and depression. "We have discovered a receptor for CRH and know its chemical structure. We are developing new drugs known as CRH antagonists that represent a new class of antidepressants," said Charney.

Scientists have also discovered a neurochemical, stresscopin, that can reduce anxiety and fear. Charney got a few laughs when he told members of Congress and congressional aides that they want a lot of this chemical in their brains.

"If we can figure out how to increase this peptide in the brain, we may be able to prevent anxiety and depressive disorders," said Charney.

Best and Worst of Times

Steven Sharfstein, M.D., president and CEO of Sheppard-Pratt Health System in Baltimore, said psychiatrists are living in "the best of times" because of recent advances in brain research. He recalled prescribing lithium when it became available for patients with bipolar disorder and seeing the difference it made in their lives.

see *Lunch Briefing* on page 33

When Residents Speak Out

BY JOHN MARTIN-JOY, M.D.

“But you’re usually so mild-mannered!” It was true. Far from an activist, I thought of myself as quiet, responsible, and deferential. Overjoyed to be at the Harvard Longwood Psychiatry Residency Training Program, I was in love with the unexpected beauty of patients’ stories and the elegance of psychodynamic thinking. I had especially sought training at Beth Israel-Deaconess Medical Center (BIDMC), one of three Boston hospitals (with Brigham and Women’s Hospital and the Massachusetts Mental Health Center) that make up the Harvard Longwood psychiatry residency.

I considered BIDMC a haven of wonderful teaching and humane patient care. My colleagues and I were looking forward to years of learning thoughtful psychiatry there.

All of that changed suddenly one morning in September 2000. Residents started to drift into the department office stunned and glassy-eyed. A few had read the e-mail sent the night before by the CEO of the financially ailing network that owned BIDMC. Others had heard the news on morning radio: The network had decided to eliminate virtually the entire BIDMC psychiatry department.

Residents, teachers, administrators, and patients were in shock. Placing financial priorities first, the CEO had set the goal of a smaller, more efficient medical center—but one without primary psychiatric services. BIDMC’s two inpatient psychiatry units and its outpatient department would be closed. Only a small consultation-liaison service would remain.

Shock quickly gave way to anger. Incredibly, the CEO had consulted with no one in the department or the community. There was already a shortage of psychiatric beds in Boston; the network’s move would exacerbate the crisis. Yet the CEO’s announcement proclaimed that “our patients. . .always will come first.”

For residents, there was an additional bitter pill. BIDMC was a major participant in the Harvard Longwood psychiatry residency. Without its involvement, our nationally recognized training program was suddenly in jeopardy. Neither the CEO nor anyone at the network had approached the residency before making the announcement.

Like my colleagues, I was furious. Yet deciding how to act was difficult. What would people think of residents who spoke out publicly? Would protest help or hurt? In supervision I described my dilemma: I wanted badly to write a protest letter. But to whom? The CEO? The dean of the medical school? And at what cost? If I spoke out angrily, perhaps people would look askance at me.

Finally, my supervisor asked me what I felt more than anything. “Betrayal,” I answered. I dismissed this strong emotion as



an overreaction. But he repeated the word with a nod. “Betrayal.” Then he asked, “What do you think the dean would feel if you sent your letter to him—and used that very word?”

I paused, trying to imagine the dean’s reaction to my protest. “Anger.”

“That’s possible. But what else might he feel?”

“Well. I suppose he

could feel. . .pride.”

It finally dawned on me that a thoughtless move deserved a vigorous protest in the name of patient care and education at Har-

In the July 20 issue, Residents’ Forum discussed unions and resident organizations, using the 1967 Boston City Hospital “beal in” as a case example. In this issue Dr. Martin-Joy describes (in both personal and organizational terms) how residents in Boston in 2000 protected patients, psychiatric services, and their education from disaster by using grass-roots resident organizations, by appealing to influential parties, and by getting the story into the media. I think that such bravery and determination, as that found in Dr. Martin-Joy and his colleagues, can pay off. I would also add that putting patient care first, as was done in this case, helps focus one’s advocacy. And any one of us may one day be forced to advocate for psychiatry.

—Avram H. Mack, M.D., APA MIT Trustee

vard. And so, for me, a protest movement was born.

I summoned my courage and drafted a letter to the dean. Deliberately I chose strong words like “hasty,” “misguided,” and “unworthy” to describe the network’s decision. I decried the loss of long-cherished relationships with patients. And I concluded,

“Surely the residents who came to Harvard Longwood for its excellence as a training program have reason to feel betrayed when a major Harvard teaching hospital thoughtlessly undermines the integrity of their program.”

As I wrote, I took comfort in my colleague *Residents’ Forum* on page 30

Dr. Martin-Joy is the outpatient chief resident at Beth Israel-Deaconess Medical Center/PGY-4, Harvard Longwood Psychiatry Residency Training Program in Boston, Mass.

Small Steps Mark Progress In Understanding Autism

Parents of children with autism as well as those who work with such youngsters learn at a recent conference that some medical progress, however modest, is being made against this devastating, incurable condition that is such a big part of their lives.

BY JOAN AREHART-TREICHEL

On July 19, parents of autistic children as well as professionals who work with such youngsters gathered in San Diego to greet three young men who had cycled across the United States to increase awareness of autism and to increase funding for autism research. As the cyclists pulled into their midst, they cheered, applauded, and whistled. A marine band played "God Bless America."

The major reason the autism community had come together, however, was to attend a three-day conference sponsored by the Autism Society of America. They hoped to learn more about how to help children with autism on a day-by-day basis and especially to find out whether any medical research progress is being made against this disorder.

One message they heard was that while no major breakthroughs have been made, researchers have made some incremental progress in understanding the condition's prevalence and causes.

The complex condition, conference speakers noted, involves core symptoms such as difficulty socializing, difficulty communicating, and ritualistic behaviors such as hand-flapping or repeatedly lining toys up in a row. But it can also include mental retardation, seizures, sleep problems, gastrointestinal troubles, inattention, hyperactivity, tics, and decreased response to pain yet excessive sensitivity to other sensory stimuli.

In other words, no two persons with autism have identical features of the disorder. One, for instance, may be profoundly impaired in hearing comprehension yet



People interested in autism prepare to greet the three young men who have cycled across America, from New York City to San Diego, in order to increase awareness of autism and funds for autism research.

have visual understanding, whereas another may display the opposite.

Is autism truly increasing as many reports have indicated? Probably not, reported Judith Grether, Ph.D., a research scientist with the California Department of Health Services in Oakland. California has a Department of Developmental Services with 21 regional centers that diagnose children with autism and other developmental disorders. The department also keeps track of the prevalence of autism diagnoses over the years. So Grether and her colleagues decided to use the department's database to determine how many children in California were diagnosed with autism or mental retardation without a known cause between 1987 and 1994.

They found that there had been an increase in the number of children diagnosed with autism between 1987 and 1994, yet during those years there had been a comparable decrease in the number of children diagnosed with mental retardation of no known cause. "So there was probably a shift in diagnosis during those years, not an increase in autism," Grether and her team concluded.

The conference speakers also addressed theories of what causes autism. Might it be the measles-mumps-rubella vaccine? After all, some parents of children with autism suspect that the vaccine might be at fault, since their children's autism symptoms started around the same time that the children received that vaccine, which is usually at 18 months of age. Yet evidence suggests that the vaccine is probably not a culprit, reported Eric Courchesne, Ph.D., director of the Research on the Neuroscience of Autism Laboratory at the University of California at San Diego. Grether agreed: "At this point there is not a credible connection, and I am talking about a number of studies."

However, other investigations into this possibility are underway, Grether admitted. Courchesne said that some of these studies were being conducted by the National Institutes of Health in Bethesda, Md. Scientists are taking these studies very seriously, he said.

Evidence does continue to mount that

genes play a major role in autism. For instance, if one identical twin has autism, the other has a 60 percent chance of also having it, reported Karin Nelson, M.D., a child neurologist and acting chief of the Neuroepidemiology Branch of the National Institute of Neurological Disorders and Stroke in Bethesda, Md.

Also, if parents already have one child with autism, their chances of having another with it are 3 percent to 5 percent greater than the general population's risk of having a child with the condition, Nelson pointed out.

Nonetheless, getting a handle on the culprit gene or genes is turning out to be tougher than scientists anticipated. There are about six laboratories throughout the world that have been in hot pursuit of autism genes, including that of Donna Spiker, Ph.D. Spiker is clinical director of the Stanford Autism Genetics Project, which is part of the department of psychiatry at Stanford University School of Medicine. Yet while several promising locations for autism genes have been identified, for example on chromosome numbers 7 and 15, none of the results have been replicated across all of the study groups. So "there seem to be numerous genes with small effects," Spiker said.

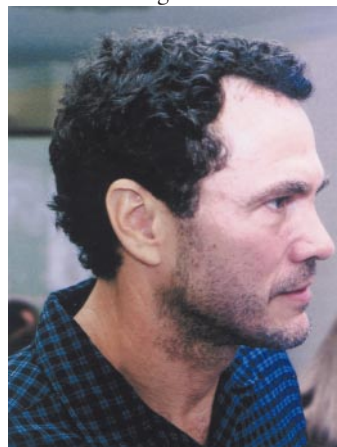
Also challenging researchers in pursuit of the causes of autism is the fact that so many areas of the brain can be affected by the condition—the frontal lobe, temporal lobe, parietal lobe,

amygdala, hippocampus, and corpus callosum, for example. Yet one brain area—the cerebellum—does appear to be consistently affected in autism patients, reported Karen Pierce, Ph.D., a senior research scientist in Courchesne's lab. This consistency may give researchers a tip on where to look for causes.

A new discovery by Nelson, Grether, and colleagues, however, may bring investigators even closer to the origins of autism than the cerebellum has.

They collected blood that had been taken from 246 subjects at birth and stored in a deep freezer. Of the 246 subjects, 69 had autism, 60 mental retardation, 63 cerebral palsy, and 54 were healthy controls. They then analyzed the blood sam-

see *Autism* on page 33



Eric Courchesne, Ph.D., is director of the Research on the Neuroscience of Autism Laboratory at the University of California at San Diego.

Drugs, Unconventional Treatments May Help

"At this point we do not have a medication that can cure autism, so if a doctor tells you that there is one, get up and run away!" This was the advice that Luke Tsai, M.D., a professor of psychiatry and pediatrics at the University of Michigan Medical School and director of the school's Developmental Disorders/Autism Program, gave those persons attending the national autism conference in San Diego in July.

Nonetheless, he reassured them, some psychotropic drugs can lessen some of the symptoms of autism—for example, the difficulty paying attention, ritualistic actions, or tics. The serotonin-reuptake inhibitors, he added, may also make autism patients a bit more sociable, although there are really no medications that can improve their social skills or help them with speech development.

For the approximately 30 percent of autism patients who experience seizures, anticonvulsants such as carbamazepine and valproic acid can help, reported Roberto Tuchman, M.D., a child neurologist and clinical assistant professor of neurology at the University of Miami School of Medicine. The reasons such medications help autism patients, he explained, may have to do not only with their ability to counter seizures, but with their ability to stabilize moods.

Some unconventional treatments might also benefit autism patients, various conference speakers indicated. One was Amy Holmes, M.D., a radiation oncologist from Baton Rouge, La.

Holmes related how for 15 years she and her husband, also a physician, had tried to have a child. And when one finally arrived in 1995, they were overjoyed. At first their son appeared to be healthy and happy. But as the months went by, he started to retreat into himself. "He treated my husband and me like pieces of furniture," Holmes recalled, and as his grandmother started to notice, "He has become a most unloving child." He would sit and focus on a leaf for hours at a time, she noted. In 1997 a pediatric neurologist diagnosed him as having severe autism.

Holmes and her husband gave him various types of medications as well as speech therapy, but those interventions did not help him. In fact, he continued to regress. So they started exploring some unconventional treatment routes and in the process learned that he had high levels of lead in his body. So they took steps to have it removed, and afterward his attention and language improved a little. They then determined that he had high levels of mercury in his body and acted to remove that as well.

After those procedures, Holmes said, his I.Q. improved, and he started catching up on months of language development. By December 2000, she said, his I.Q. had reached the normal range, and as of this summer, he no longer meets diagnostic criteria for autism. He can participate in conversation, play with other children, ride a bike, and roller blade. He will start first grade in the fall.

Holmes was so overwhelmed by the dramatic improvement in her son's health that she decided to conduct an open pilot study to see whether mercury removal might also benefit other children with autism. Of the 152 children who participated, 54 (36 percent) experienced some improvement, she said. Holmes is planning to publish the pilot study's results and also to conduct a double-blind, placebo-controlled trial to further explore and document the value of the technique against autism.

Not surprisingly, many physicians view such unconventional treatments with skepticism or downright hostility, said Paul Hardy, M.D., a neurologist and psychiatrist from Hingham, Mass. Even up to four years ago, he admitted, he thought that such treatments were bogus. However, he now believes that such treatments should be given a chance and that there may even be some value to them.

Several Institute Sessions Designed for Residents

Part of the mission of the Institute on Psychiatric Services is to be a user-friendly and welcoming meeting for psychiatry residents. To that end, the institute includes many scientific sessions and social events specifically for residents.

Residents are important to the success of APA meetings, especially the Institute on Psychiatric Services (IPS). To meet their needs, APA has scheduled several activities for residents at the IPS meeting. There will be a reception open to all residents and early career psychiatrists to network with colleagues and APA leaders. The reception is scheduled for Thursday, October 11, from 5 p.m. to 6 p.m.

Also on the agenda is the annual Meet

the Experts Luncheon, which is funded by Janssen Pharmaceutica. This luncheon, which continues to be an important part of resident activities both at the APA annual meeting and the IPS, features topics of interest to residents and ECPs.

Topics and experts for this year's Meet the Experts Luncheon include Ana E. Campo, M.D., who will address academic careers; Kenneth Minkoff, M.D., and Wesley E. Sowers, M.D., for addiction and substance abuse; David Fassler, M.D., on child and adolescent psychiatry; Wade C. Myers, M.D., on forensic aspects of child and adolescent psychiatry; Albert C. Gaw, M.D., for cross-cultural training and cultural competency; Judith Lifton, M.D., on disaster psychiatry; Gail Barton, M.D., for emergency psychiatry; Stephen Goldfinger, M.D., Alan D. Felix, M.D., and Hunter McQuiston, M.D., for homelessness and poverty; James W. Thompson, M.D., and Richard K. Harding, M.D., on leadership development; Joel S. Feiner, M.D., and Jacqueline M. Feldman, M.D., on public and community psychiatry; Marcia Kraft Goin, M.D., for psychotherapy; Phillip Wayne Cushman, M.D., for

IPS Offers Discount Car Rentals In Orlando

Avis is the official rental car company for APA's 53rd Institute on Psychiatric Services. Discounted rental car rates will be given to all attendees by calling (800) 331-1600. The Avis Worldwide Discount number is A880099. Please use this number when calling Avis directly.



SeaWorld Orlando is across the road from the site of this year's Institute on Psychiatric Services.

technology and psychiatry; Carl Bell, M.D., and Edward Hanin, M.D., on violence and psychiatry; and Nada L. Stotland, M.D., and Ann Ruth Turkel, M.D., for women's mental health.

The Meet the Experts Luncheon is scheduled for Friday, October 12, from 12 noon to 1:30 p.m.

APA's Member-in-Training Trustee, Avram H. Mack, M.D., will lead the residents in a discussion on "Whither Residency Training Amidst Corporations, Unions, Mergers, and Closures?" This workshop is scheduled for Saturday, October 13, from 8 a.m. to 9:30 a.m.

For this meeting as well, APA has announced the creation of a new APA/Janssen Resident IPS Travel Schol-

arship Program. This travel program was created to generate interest in community and public psychiatry, since APA believes it is imperative to expose residents to the most exciting new clinical research and the most successful public programs for the treatment of the seriously mentally ill. The APA/Janssen Resident Travel Scholarships Program will provide residents with these opportunities through attendance and mentoring activities at the IPS meeting.

For more information about residents' activities including the APA/Janssen Resident IPS Travel Scholarship Program, contact Nancy Delanoche at (202) 682-6126 or by e-mail at ndelanoche@psych.org. ■

Debates Promise to Be Controversial, Informative

BY CHARLES HUFFINE, M.D.

Debates at the upcoming Institute on Psychiatric Services promise to be thought-provoking and controversial. The clinical consultation sessions allow members to interact with leading clinicians and educators.

The 53rd Institute on Psychiatric Services (IPS) will feature four clinical consultations and two debates. These two formats offer op-

portunities for engagement with leaders in psychiatry unique to the IPS.

The first debate, scheduled for Thursday, October 11, from 1:30 p.m. to 3 p.m., will feature the candidates for president-elect of APA debating issues of importance to APA members. This annual debate has been an excellent opportunity to take the measure of the candidates, ask them tough questions, and get to know them as they grapple with the tough issues.

The second debate is sponsored by the American Association of Community Psychiatrists. It will address the resolution that faith-based mental health and substance abuse services should have liberalized access to federal funding. This issue is currently being debated in Congress and many other forums.

Anita Everett, M.D., who will argue the affirmative position in this debate, is the inspector general for the Commonwealth of Virginia's Department of Mental Health. Living in a state with conservative religious and political traditions, she has come to appreciate the relevance of this cultural factor to consumers of mental health services in her state. David Pollack, M.D., who will take

the negative position, has recently spent a year as a Robert Wood Johnson senior policy fellow with the U. S. Congress, assigned to Senator Edward Kennedy's staff. He became aware of a trend in legislative proposals from religiously conservative senators to push the issues of liberalized access for faith-based groups to the point of threatening quality of medical care.

This debate should be an excellent exposition of complex and compelling issues from multiple perspectives. Drs. Everett and Pollack are both Board members of the American Academy of Child and Adolescent Psychiatry and have deep commitments to the treatment of individuals with serious and persistent mental illness.

The clinical consultations format offers a very interactive and stimulating opportunity to engage with leaders in psychiatry on issues core to our field.

Carol Bernstein, M.D., from the New York University School of Medicine, will consult on critical issues in psychiatric education on Thursday, October 11, from 10 a.m. to 11:30 a.m. Dr. Bernstein, who is also the APA treasurer, recently served as APA's representative on the Residency Review Committee.

David C. Lindy, M.D., associate clinical professor of psychiatry at Columbia University and clinical director of the Visiting Nurse Service of New York, will offer a consultation on using countertransference in the treatment of patients who act out. It will be held on Friday, October 12, from 10 a.m. to 11:30 a.m.

Dwight A. Owens, M.D., of Morehouse School of Medicine in Atlanta, will consult

regarding differential diagnosis of psychosis on Friday, October 12, from 3:30 p.m. to 5 p.m.

Andres Pumariega, M.D., from the James H. Quillen College of Medicine at East Tennessee State University, will host a consultation on culturally competent diagnosis and treatment. It is scheduled for Saturday, October 13, between 3:30 p.m. and 5 p.m. and is sponsored by the American Association of Community Psychiatrists.

The Scientific Program Committee is pleased that these leaders in our field have offered such outstanding opportunities for learning and sharing ideas. We hope that APA members will find them stimulating and informative. ■

Dr. Huffine is a member of the Scientific Program Committee for the APA Institute on Psychiatric Services.



The Kennedy Space Center visitor complex is about an hour's drive from APA's Institute on Psychiatric Services.

‘The Sopranos’

Dr. Herbert Peyser’s Viewpoints article in the June 1 issue is a stimulating, well-written commentary on the behavior of the psychiatrist in HBO’s “The Sopranos.” He criticizes her for treating Tony Soprano, a fictitious New Jersey mobster who has developed panic attacks in midlife.

Viewers learn early in the series that Tony Soprano is a killer and sociopath, and the psychiatrist knows it. Dr. Peyser criticizes the psychiatrist both on moral grounds for accepting such a bad person as a patient, as well as on technical grounds by remaining silent and “neutral” while the patient haltingly, and with much resistance, tells his story. In his opinion, the psychiatrist is incompetent, and if he were examining her for the boards, he would flunk her. Dr. Peyser pointed out, however, that he had

seen only a “bit of the show” (several episodes?).

Being a bit of a devil’s advocate, since I agree Tony is a “high-risk, difficult-to-treat” patient whom practically no one should be “required” to accept, I nonetheless disagree with his opinion.

Now that I am (mostly) retired after 37 years of psychiatric practice (and other years as a Navy doctor), my wife and I have time to browse at Blockbuster Video, where, out of curiosity, we took out the first nine episodes of “The Sopranos.” At first, after several episodes, we would have agreed with Dr. Peyser: The psychiatrist was using poor judgment, seeming to countenance violence, practicing rescue psychiatry or “Red Cross-ing,” at times being unconsciously seductive—overall, she was playing with fire and had bitten off more than she could chew. She was even risking her life as the sinister

Capo “Uncle Junior” became aware that his nephew, Tony, might be blabbing to his psychiatrist. She also was the verbal target of several of the patient’s rage attacks.

In later episodes, however (get on down to Blockbuster, Dr. Peyser, and take out a few more episodes), this psychiatrist’s incredible courage, fearless dedication, and commitment to the patient emerge. By the ninth episode (that’s as far as we’ve gotten since we don’t have HBO), Tony has actually begun to change his behavior: At the last minute, and despite his ambivalence, he has canceled a “hit” on a soccer coach who had seduced a teenaged friend of his daughter and decided (after consultation with the psychiatrist) to leave the coach’s punishment up to the police and courts.

Thus, as we continued to watch, we felt that “The Sopranos” is a fascinating, beautifully written, and brilliantly cast series that

portrays a psychiatrist as a complex woman and psychiatric physician who exemplifies the highest values of our calling: courage and commitment to the individual patient, but not without that “certain risk to one’s own personal safety” that Justice Holmes averred was necessary to being truly alive. I’m also reminded of Freud’s comment on being asked what he planned to do now that he had to go into private practice to support his family: “I plan to do my best by whatever patient comes my way. . . .”

JOHN L. KUEHN, M.D.
Medina, Ohio

In his Viewpoints article in the June 1 issue, Dr. Herbert Peyser severely criticizes the portrayal of psychiatrist Jennifer Melfi as performed by Lorraine Bracco in the “mega hit” HBO television series “The Sopranos.” I could not disagree more with his critique. The majority of my mental health care practitioner colleagues, including many psychoanalysts, agree that the characterization of Dr. Melfi exhibits a rare brilliance and depth in its description of the world of a practicing psychiatrist and of the psychotherapeutic process.

I would dare say that “The Sopranos” has done more to destigmatize mental illness (through educating the public about such clinical diagnoses as panic disorder and antisocial and borderline personality disorders), reveal to the American public what goes on behind the closed doors of the therapist’s office, and help define what a psychiatrist is than any public relations initiative ever promulgated by our own professional guild organization.

APA should acknowledge this important contribution by honoring the body of work by the creators, producers, and writers of “The Sopranos.”

Dr. Peyser asserts that he would have flunked Dr. Melfi if he had examined her for the boards. I say, “Fogetaboutit.”

BARRY K. HERMAN, M.D.
Austin, Tex.

Mind and Gut

The article in the July 20 issue describing Dr. Michael Gershon’s lecture at APA’s 2001 annual meeting brought the biological basis of disorders of the G.I. tract to the fore. We must continue to emphasize the biopsychosocial underpinning of disorders of behavior and/or functioning. Eating disorders in particular are puzzling disorders because we have yet to fully explore the underlying biology. Dr. Gershon’s work brings us a step closer to answers.

Eating behavior is part of two of our most basic needs—human attachment and nourishment. Add a “gut that has a mind of its own” and its physiological vulnerabilities and we have puzzling clinical pictures to decipher. The mysterious

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Medicaid

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ing from restriction of medication for persons with mental illness usually are more than offset by increases in spending by other service sectors.

The coalition achieved a partial victory when Senate Bill 471 passed both houses of the 2001 session of the Indiana General Assembly. That legislation stipulated that Medicaid recipients should be able to receive prescription drugs that are used for the treatment of a mental illness without any restrictions or limitations, including prior authorization, when the prescription drug is used for the treatment of a mental illness.

Governor Frank O'Bannon (D), however, vetoed the legislation, citing "cost considerations" and asked the Medicaid office to come up with other approaches to the problem. Coalition members plan to continue their struggles to ensure access to appropriate medication.

Wernert said, "There is no question in my mind that prior authorization as a cost-saving measure will be instituted in our Medicaid drug program. Our strategy is to make sure that psychotropics are the very last medications considered for prior authorization, not the first. Similar models in other states, like West Virginia, have well over 30 classes of medicines under prior authorization, but have not touched psychotropics."

In a telephone interview, Buck expanded on his federal perspective about the increasing importance of Medicaid. "Mental health services are a relatively small part of the Medicaid program. Excluding funds spent on drugs, only about 10 percent of total Medicaid funds go to mental health."

"So," he added, "mental health is only one of many issues for Medicaid. But for anyone concerned about mental health,

Medicaid is a 1,000-pound gorilla. We have to start thinking about how to integrate that program into the mental health system."

At the state level, in Indiana, Wernert agreed. "It is already true that Medicaid is the primary source of funds for public mental health. [Its importance] will only continue in the future since most states have closed their state-sponsored institutions, and persons with chronic mental illness are living in the community and drawing Medicaid."

He added a word of advice for other practitioners: "We must stay vigilant."

Numerous reports on the topic of managed care and Medicaid are posted on the Web at <www.mentalhealth.org/cmbs/managed-care/index.htm>. Information on Indiana Senate Bill 471 can be accessed on the Web at <www.ai.org/serv/lsa_billinfo> by entering "471" in the "Go to Bill" box. ■

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a position critical to our patients and our profession.

APA-PAC is established as a voluntary, nonprofit, unincorporated committee of psychiatric physicians who donate money to candidates seeking federal elective office. APA-PAC is and will be bipartisan, representing all of psychiatry. In order for it to be vigorous and a potent force, we need your help.

Psychiatrists have traditionally been lousy politicians. Many APA members find the national political process distasteful, but our choice is a simple one—have a seat at the table or cede our place to others who most certainly do not have our patients' and psychiatry's best interest in mind.

If we are not prepared to back up our advocacy with tangible support for our po-

litical friends and tangible opposition to those who oppose us, then we will pay a heavy price. Simply put, an effective PAC is one part—a vital part—of a coordinated grassroots strategy that includes lobbying by psychiatrists on a national and local level.

This will be the first time that APA has had a political fundraising voice and that APA members will be able to participate individually in furthering the goals for patients and the profession of psychiatry in this regard.

To make the launch of APA-PAC successful, you will be able to make a voluntary contribution to the PAC by simply marking the APA-PAC "check off" box on your APA 2002 dues billing statement. The success of APA-PAC depends 100 percent on voluntary support. It is vital that all psychiatrists understand the importance of this effort. Everyone's participation is essential. ■

letters to the editor

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ous gut is finally getting our attention. There is another condition that is often overlooked. Cancer of the G.I. tract or digestive organs may present as anorexia or symptoms of digestive dysfunction.

Although not as frequent as breast or lung cancer in the United States, G.I. and intra-abdominal cancers are often silent or present with symptoms related to eating. Although rare, stomach cancer has been reported in adolescents.

SEANA SHAW, M.D.
Miami Beach, Fla.

JCAHO Appointment

It is with interest that I read in your July 20 issue of the appointment of Dr. Joseph English as an AMA appointee to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which incorrectly states that Dr. English "will be the first psychiatrist to sit on the JCAHO board." Dr. English was quoted as saying, "This is really a historic and momentous time for American psychiatry." Please be advised that I served three terms as an AMA appointee to the JCAHO Board from 1968 to 1976.

LESTER H. RUDY, M.D.
Rockford, Ill.

Parity Bill

continued from page 1

mittee chair Sen. Edward Kennedy (D-Mass.). Along with Wellstone, Sen. Pete Domenici (R-N.M.) is a lead sponsor of S 543.

The bill passed unanimously with one amendment, which changed the language that exempts small employers from those with 25 or fewer employees to those with 50 or fewer, which is consistent with the 1996 law.

The bill requires health plans that provide mental illness coverage to apply the same treatment limitations and financial requirements that are imposed on physical illnesses. That means the same limits on the frequency of treatment, number of visits or days covered, and the same deductibles, coinsurance amounts, copayments, and other-cost sharing requirements, according to the legislation.

The 1996 parity law prohibited only discriminatory annual and lifetime dollar limits for mental health care. The fact that the 1996 law, also cosponsored by Domenici

and Wellstone, is scheduled to sunset at the end of this month has provided an impetus for passing S 543 quickly. A floor vote had not been scheduled as of press time.

The version approved by the committee allows mental health benefits to be managed through utilization review and applying medical-necessity criteria, according to the bill.

The bill defines mental illnesses as all categories of mental health conditions listed in the current edition of the *DSM* but excludes substance abuse disorders.

Before the mark-up, some committee members including Sen. Bill Frist (R-Tenn.) suggested limiting the definition of mental disorders to “biologically based illnesses” (*Psychiatric News*, August 3). However, they were educated by APA staff about the importance of covering all *DSM* mental disorders in the legislation, according to Michael Strazzella, deputy director for congressional relations in APA’s Division of Government Relations.

Ranking Republican committee member Judd Gregg (R-N.H.) said at the mark-

up, that he voted for the bill with the intent of offering an amendment during the floor debate to exempt employers from the parity mandate if their insurance costs increase more than 1 percent. The cost exemption language is also in the 1996 parity law.

APA is opposed to adding a cost exemption to the parity bills. The Congressional Budget Office recently estimated that the Senate bill would only increase insurance premiums by 1 percent, according to Ellen Gerrity, Wellstone’s legislative assistant for mental health and addiction issues.

“This is negligible compared with the \$79 billion in indirect costs in 1990 due mainly to lost productivity caused by mental illness, and the \$69 billion in direct treatment costs in 1996 reported by the Surgeon General in his 1999 report on mental health,” remarked Wellstone at the committee’s session.

The bill, which had 54 cosponsors at press time, would not preempt stronger provisions in state parity laws.

APA supports parity for substance abuse disorders, which is included in House parity bill HR 162. Differences between the House and Senate parity bills would have to be worked out in conference, if they pass their respective chambers.

The House bill, which had 155 cosponsors at press time, was still in committee.

The status and summaries of the House and Senate bills are available on the Thomas legislative Web site at <thomas.loc.gov> by searching on the bill number, HR 162/S 543. ■

residents’ forum

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leagues’ support and activism. Suddenly all of us were rising to the challenge of opposition. One resident gave scorching interviews to the media. Others contacted legislators and joined a protest march on Boston Common. Still others worked with faculty and professional organizations, developing responses to the crisis.

With my colleagues’ support, I decided to present my letter to the residency’s house officers’ association—not as an individual protest, but as the draft of a unanimous statement by all 60 Harvard Longwood psychiatry residents. Residents were enthusiastic. But the group worried, as I had, about how outspoken it was acceptable to be. Some strongly favored an angry statement; many argued for toning the letter down. We finally decided that the word “shameful” and its variations, which I had used three times, should appear only once. But the tone of outrage remained intact, and the residents unanimously approved the revised letter. To my delight, a whole series of Longwood supervisors and mentors also made their support extremely clear.

Partly as a result of our massive outreach, our own protest was joined and strengthened by others. The CEO heard from faculty, BIDMC department heads, professional organizations, patient advocacy groups—and the dean of the medical school. Articles appeared in professional and general newspapers. Outraged over the network’s decision, Massachusetts Medical Society residents brought a measure opposing mental health insurance “carveouts,” which eventually became AMA policy. (These carveouts worsen the financial crisis at teaching hospitals everywhere.) Then APA president Dan Borenstein, M.D., condemned the network’s action in a forceful letter. The Massachusetts Department of Mental Health, the Department of Public Health, and the mayor of Boston all insisted that BIDMC’s inpatient beds were vital. There were threats to review the network’s decision publicly and to look closely at future building permits for BIDMC expansion.

Under such intense pressure, the CEO relented. In October he restored the outpatient psychiatry department and announced that BIDMC would continue to participate in the residency. In early 2001, to widespread cheers, he announced that the network would keep a scaled-back inpatient unit at BIDMC.

Against great odds, the BIDMC psychiatry department and the Harvard Longwood psychiatry residency have survived intact. Residents have realized that we can overcome our inhibitions and speak out against misguided decisions. But we’ve also learned that we can meet adversity by working together. A year after the crisis, we’re still teaching, still caring for patients, and proudly looking to the future. ■

Alcohol Use

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that the comparison of data from the MTF and the ESPAD provides no evidence that less-restrictive regulations on alcohol sales and consumption in Europe have led European youth to drink more responsibly than their counterparts in the U.S.

In a separate report issued in August the Substance Abuse and Mental Health Services Administration released data from the 2000 Drug Abuse Warning Network (DAWN) Report showing that although American youth may fare better than most European teens when it comes to problematic drinking, alcohol consumption when combined with other drug use remained the leading cause of drug-related visits to emergency rooms last year.

The DAWN report is an annual survey of hospital emergency departments designed to collect data on emergency department admissions related to use of an illegal drug or the nonmedical use of a legal drug. The survey is used to estimate the effects of drugs on the health of substance abusers rather than actual prevalence of drug use by the U.S. population.

The 2000 survey showed that the number of drug-related emergency room visits remained relatively stable from 1999 to 2000, with just over 600,000 admissions nationally.

The most commonly mentioned drugs causing an emergency room visit also did not change from 1999 to 2000, with alcohol in combination with any other drug (34 percent) again topping the list, followed by cocaine (29 percent), heroin/morphine (16 percent), marijuana/hashish (16 percent),

amphetamines (3 percent), and methamphetamine/speed (2 percent).

Emergency room records mentioning cocaine and marijuana or hashish did not change from 1999 to 2000, but there were significant increases in admissions due to amphetamine use (up 35 percent from 1999), PCP (up 32 percent), methamphetamine/speed (up 13 percent), and heroin or morphine (up 15 percent).

Males continued to have the highest overall rates of drug-related emergency room visits during 2000, and the rates remained steady. Such drug-related visits for females, however, rose 9 percent.

The racial/ethnic mixture of patients admitted remained relatively stable from 1999 to 2000, with one striking exception. Drug-related emergency room visits for patients of Hispanic background rose 20 percent.

There were also striking changes based on age categories. From 1999 to 2000, ER visits rose 20 percent for patients 12 to 17 years old and 13 percent for patients aged 18 to 25 while remaining stable for patients older than 25.

"This report shows again that we face serious gaps in preventing and treating substance abuse, especially with club drugs," said Health and Human Services Secretary Tommy G. Thompson. "Our first line of defense against substance abuse must be prevention. We need to reach out to people before they become statistics in emergency departments—or worse, in the morgue."

The OJP comparison report is available online at <www.udetc.org/publications.htm>, by clicking on the heading "Comparison of Drinking Rates and Problems." The 2000 DAWN data are available at <www.drugstatistics.samhsa.gov> by clicking on the DAWN icon on the left. ■

Satcher

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present burden of mental illness stigma.

The Surgeon General noted that there have been people who have committed suicide who never acknowledged that they were depressed, and families who didn't feel comfortable getting mental health treatment for their child.

"And when communities don't make mental health services available—when there is no parity of access to treatment, and when our policies do not reflect the need for that parity, stigma is working on the community level," said Satcher.

David Brandling-Bennett, M.D., deputy director of the Pan American Health Organization, the regional office of the World Health Organization (WHO), attributed both stigma and a lack of resources to problems on a global scale.

"Millions of people with mental illness do not have access to treatment, and beyond that, many suffer human rights violations as a result of their disabilities," remarked Bennett.

Bennett, who has spent considerable time working in Thailand and Kenya, where he was in charge of the research and the control of tropical and vaccine-preventable diseases, used numbers to convey some alarming truths.

"We estimate that in our part of the world, particularly in Latin America and the Caribbean, the lifetime prevalence of mental disorders is 20 to 25 percent," he said, warning that these numbers were likely to increase.

For instance, according to Bennett, the WHO projects that the number of people living with major depression worldwide is likely to rise from 20 million to 35 million in the next 20 years.

The number of people living with schizophrenia is projected to go from 3 million to 5.5 million by 2020.

To better treat people with mental illness, Bennett recommended that develop-

"Millions of people with mental illness do not have access to treatment."

ing countries implement mental health policies and that advocates urge psychiatrists and mental health professionals in those countries to utilize evidence-based practice guidelines.

Bennett also urged the recognition of special populations of people with mental illness, particularly those living in rural areas, the poor, and minorities, all of whom are less likely to have access to psychiatric treatment.

Perhaps NAMI's new executive director Richard Birkel, Ph.D., who joined Satcher and Bennett on the panel, best summed up the experiences of people living with mental illness in attendance that day.

"You've risen from fear, despair, and disbelief through anger, cynicism, and exhaustion," said Birkel, "but you have returned, each time, stronger, better organized, and smarter." ■

Kim

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With 20 newly trained psychiatric nurse practitioners in the Seoul area, Kim then created a voluntary task force to help reform the mental health system by establishing the first nurse-managed community mental health program.

"This is something unimaginable in a country where the medical profession dominates the health care delivery system," she said. "Two district health centers rejected our idea of approaching local residents, simply because we were nurses."

However, Kim and her colleagues eventually made an arrangement with a health center in a poor section of Korea to approach residents to help locate people with serious mental illness. "Our first goal was to locate long-term psychiatric patients who were confined at home without care," said Kim.

The psychiatric nurse practitioners went door to door and found 204 people with mental illness who had received no care.

Kim applied for a grant from the United Nations Development Program for \$1,000 to fund bus fare, lunches, and daytime activities for the people. "In the end, the \$1,000 proposal became a \$300,000 project to develop easily accessible and cost-effective treatment that would offer quality mental health care and become part of a social

rehabilitation program," proclaimed Kim.

The project aimed to rehabilitate long-term psychiatric patients to decrease the need for future hospitalization and maximize social functioning. It made use of 61 volunteers, including psychiatrists, psychologists, social workers, and the nurse practitioners.

Project staff not only provided care at the community mental health center but also within homes, where staff taught families about mental illness, medication compliance, stress management, effective communication skills, and symptom management.

Kim and her colleagues also used various "interpersonal caring techniques" with the patients, which included comforting, sharing, and active listening, for instance. In a study of the project, Kim found that patients who had been exposed to these simple techniques had benefited enormously.

"They made extraordinary progress in terms of daily living skills, self-care activities, family support, and family burden compared with the control group," said Kim. Additionally, for this group, the average length of hospital stays after two years decreased from 231 days per year to just 13 days.

"Families, consumers, and mental health professionals today have challenging opportunities to create new therapeutic modalities," said Kim. ■

Anosognosia

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"Don't expect them to comply with any treatment plan, because they don't believe they are ill," noted Amador.

It is important instead to develop a partnership with the patient around those things that can be agreed upon.

Amador said that family members and clinicians should first listen to the patient's fears, such as being placed in the hospital against his or her will.

Empathy with the patient's frustrations and even delusional beliefs is also important, remarked Amador, who said that the phrase "I understand how you feel" can make a world of difference.

The most difficult thing for family members to do in building a trusting relationship, he said, is to restrict discussion to the problems that the person with mental illness perceives as problems. "You might see the hallucinations or delusions as the big problem," said Amador. "Your loved one, however, may be complaining about not

getting to sleep at night. That is the problem you should be discussing."

Perhaps a patient will only take his or her medications to get family members and clinicians to quit bothering them, and this is sometimes enough, Amador said. "You have to find out what motivates them to take their medications, then reflect that reason back and highlight the perceived benefits."

Amador wrote about getting people with serious mental illness to accept treatment in a book he coauthored with Anna-Lisa Johanson (see story on page 13) titled, I am Not Sick, I Don't Need Help: A Practical Guide for Families and Therapists, published in 2000 by Vida Press. It can be purchased online at <www.vidapress.com/INSIDNH-Main.htm> for \$15.95. Ten percent of all proceeds go to NAMI, the National Alliance for Research on Schizophrenia and Depression, the National Depressive and Manic-Depressive Association, and a fund set up by David Kaczynski, brother of Theodore, to help the victims of the unabomber. ■

Awards

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velopment of new treatments for mood disorders. Using this technology, Renshaw and colleagues were able to discover altered levels of the brain chemical choline in depressed patients.

Winners of the fourth annual Freedman Award for outstanding achievement in basic science research, each of whom also received \$1,000, were:

- Kelsey Martin, M.D., Ph.D., assistant professor of psychiatry and behavioral sciences at the Brain Research Institute at the University of California at Los Angeles. Martin studied synaptic plasticity, which is involved in learning and mem-

ory processes in the brain. She researched the molecular mechanisms in the brain related to both long-term and short-term memory.

- Michael Caterina, M.D., Ph.D., assistant professor in the department of biologic chemistry at Johns Hopkins University School of Medicine. Caterina's research has led to new discoveries about the underlying biology of pain, and how a compound found in hot chili peppers plays a role in activating certain pain receptors.

- Aurelio Galli, Ph.D., assistant professor in the department of pharmacology at the University of Texas Health Science Center, San Antonio. Galli studied the mechanism by which amphetamines interact with the dopaminergic system in the brain. ■

Menninger

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involved with the three institutions worked hard, but there are some differences we have been unable to resolve. The parting is amicable. The details of the negotiations will remain confidential.”

He explained in a press conference that “There were some changes as negotiations went on in terms of money, in terms of control, and the like, most of which we were able to reach some agreement to, but I can’t be more specific” on what the snags were that led to the deal falling apart.

But for Menninger’s psychiatry residents and a couple of its leading lights, the decision to relocate to Houston has become an irreversibile one. On July 1 nine of the Menninger adult psychiatry residents and four in child psychiatry moved to Baylor. Others decided to transfer to other programs with the knowledge that the Topeka training program would be shut down.

In addition, two of Menninger’s most prominent clinicians and educators, Glen Gabbard, M.D., professor of psychoanalysis and education at the Menninger School of Psychiatry, and John Sargent, M.D., director of education and research, picked up stakes and moved to Texas, expecting it to be just a matter of time before their Menninger colleagues joined them. Gabbard is now a professor of psychiatry at Baylor, director of psychotherapy training, and director of the Baylor Clinic. Sargent has become the head of child psychiatry at Houston’s Ben Taub Hospital, one of Baylor’s teaching hospitals.

Gabbard told *Psychiatric News* that he is “disappointed” in the failure of the negotiations between Menninger and Baylor. “I anticipated that the rest of the clinic would be coming when I made my decision to move to Baylor.” By the time word of the negotiation failure reached him, Gabbard said he “was already ensconced” in his new position and enjoying his new work. “I decided to stay on” at Baylor, said Gabbard, who had been at Menninger for 26 years.

Walter Menninger acknowledged in his

statement that his organization “had a marvelous opportunity, and it slipped through our fingers.”

He noted that Menninger will continue its Topeka operations for at least the next year while it conducts a search for a new “major medical school” partner that will allow it to relocate to a metropolitan area with a much larger population of potential patients than Topeka can offer.

“There has been no interruption in our national clinical services during the period of negotiations, and there will be no interruption in the future,” Menninger said. With no move now planned before next summer, the delay, he noted, “will allow us to assure all concerned—patients and their families and the clinicians who refer patients to us—that our services will be available to them without interruption.”

Gabbard explained that he had no information on whether his other Menninger colleagues planned to remain in Topeka and wait for news of negotiations with another potential partner. “I know many of them are frustrated after a year of waiting to move and start over,” he said.

A statement issued by Methodist’s president and CEO Peter Butler said that while the agreement was motivated by his organization’s and Baylor’s desires “to increase understanding and treatment of brain disorders,” the end of the negotiations with Menninger “does not dampen our enthusiasm for pursuing this important clinical area to serve the Houston community.”

About two weeks before Menninger announced it was calling off the negotiations with Baylor, *U.S. News & World Report* published its annual survey of “America’s best hospitals,” and the magazine gave Menninger Hospital the number-three ranking among hospitals providing psychiatric care. This moved the hospital up one slot from the 2000 rankings. (Massachusetts General, a Harvard Medical School teaching hospital, led the 2001 list.)

The hospital has been licensed to have 143 beds, but as of last month its directors had reduced its licensed bed capacity to 95, and there were 60 inpatients at that time, according to a report in the *Topeka Capital-Journal*. ■

clinical & research news

they flourish; but if the brains are deprived of this protein, they do not grow properly. Vasoactive intestinal peptide is also known to be involved in the sleep-wake cycle, and autism patients often have sleep problems. Vasoactive intestinal peptide is also known to be made in the gut, and autism patients often have gastrointestinal problems.

Yet there is reason to believe that vasoactive intestinal peptide, brain-derived neurotrophic factor, and calcitonin gene-related peptide are not the only neurochemical culprits that may underlie autism, Nelson explained.

For instance, Elaine Perry, Ph.D., of Newcastle General Hospital in Newcastle-Upon-Tyne, England, and her colleagues recently reported that nerve receptors for acetylcholine—so-called nicotinic receptors—are abnormal in the brains of deceased autism patients (*Psychiatric News*, July 20). Nelson called their discovery “exciting.” She also said that since brain-derived neurotrophic factor, vasoactive intestinal peptide, and calcitonin gene-related peptide are known to influence acetylcholine, it is quite possible that all are involved in the origin of autism.

“This is not an easy story; we are not going to have snappy solutions,” Nelson admitted. “But I think we are finally on the

New Bills

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1964 Civil Rights Act, leaving gays and lesbians without legal remedies in federal courts, though a number of states and municipalities have enacted such protections within their jurisdictions.

Title 7 of the 1964 Civil Rights Act applies only to race, color, religion, sex, and national origin.

The 2001 Employment Non-Discrimination Act (ENDA) would prohibit discriminatory practices by public and private employers, employment agencies, labor organizations, training programs, and associations. All aspects of employment discrimination are covered including hiring, firing, promotion, layoffs, job advertisements, recruitment and referrals, retirement plans, and compensation.

ENDA would give gay and lesbian employees the right to file a complaint with the Equal Employment Opportunity Commission (EEOC) within 180 days of the discriminatory incident. The EEOC would then pursue the case or refer it to federal court, according to Nancy Buermeyer, deputy director for legislation of the Human Rights Campaign, an advocacy group for gays, lesbians, and bisexuals based in Washington, D.C.

Jack Drescher, M.D., chair of the APA Committee on Gay, Lesbian, and Bisexual Issues, told *Psychiatric News*, “This is a very important bill because it guarantees that people have protection from being discriminated against based on their sexual orientation. Gay and lesbian individuals are frequently mistreated at work and have no protections or legal recourse, which is antithetical to creating a safe working environment.”

The bills have bipartisan support in Congress, though not enough to guarantee passage. As of August 15 there were 181 House cosponsors and 41 in the Senate.

The Senate bill (S 1284) and House

measure (HR 2692) would exempt employers with fewer than 15 employees, the military, and religious groups.

Proponents of the legislation are optimistic that the large number of cosponsors in the House will be able to overcome strong opposition by the Republican leadership. When the legislation was first introduced in 1996, the House version was blocked from getting to the floor and the Senate bill fell one vote short of passing, Buermeyer told *Psychiatric News*.

The HRC believes federal legislation is necessary because of widespread harassment and discrimination in the workplace against gays, lesbians, and bisexuals. HRC issued a report in July that illustrates this point with more than 130 documented cases of employment discrimination that occurred nationally in the last decade. The report describes case after case of physical and verbal abuse and job dismissals. According to the HRC, this is just the tip of the iceberg because many more incidents go unreported.

The HRC also maintains federal legislation is necessary to provide uniform standards instead of the current patchwork of state and local protections. Eleven states and the District of Columbia have laws prohibiting employment discrimination based on sexual orientation in the public and private sector. Another 10 states ban this form of employment discrimination in the public sector only, according to the HRC.

In addition about 30 cities and counties have enacted laws banning public and private employers from discriminating against individuals on the basis of gender identity, sexual orientation, or “affectional preference.” Another four cities limit this type of discrimination to public employers.

Summaries, full texts, and current status of the three bills are available at the Thomas Legislative Web site at <<http://thomas.loc.gov>> by entering the specific bill number. ■

Lunch Briefing

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But, it is also the “worst of times” for psychiatrists, because of managed care restrictions on hospital stays and outpatient treatment, he emphasized.

“Although we have a parity law in Maryland, it allows for managed care utilization review. This means that I have to justify hospitalizing a suicidal patient for more than a few days and obtain new authorizations for every six sessions of outpatient treatment,” said Sharfstein.

“We need to enact a strong patient-protection bill so health plans and managed care companies know they will be held accountable for their actions,” said Sharfstein.

Jim McNulty, a person with mental illness and president of the National Alliance for the Mentally Ill, described his journey

right track, and probably all of these discoveries are pieces of the puzzle, and the challenge will be to see how well they all fit together.”

Meanwhile, parents of children with autism are eagerly awaiting a cure. “There is hope, don’t give up!” Miriam Jang, M.D., a family practitioner from San Rafael, Calif. advised one of the mothers attending the conference. Jang was in a good position to offer encouragement: In addition to being a physician and up on the latest in autism research, she has a child with autism. ■

with bipolar disorder, a condition that went undiagnosed for 17 years. The illness had a devastating impact on his marriage, which ended in divorce, said McNulty.

After attempting suicide in 1988, he was hospitalized for six weeks, which he described as starting him on the road to recovery. However, upon discharge he was referred to a primary care physician because his health insurance didn’t cover outpatient treatment sessions with a psychiatrist, said McNulty.

It wasn’t until 1994, when a parity bill was enacted in Rhode Island, that McNulty said he was able to afford to see a psychiatrist on a regular basis.

“I became a patient advocate because I couldn’t believe how hard it was for people to get mental health services and how long it took,” said McNulty. He referred to a recent survey by the National Depressive and Manic-Depressive Association showing that it takes an average of 10 years from the time people experience their first episode of bipolar illness until they are accurately diagnosed. “That is too long,” said McNulty.

He urged members of Congress and the congressional aides to reach out to people they know with mental illness and tell them that treatment works.

Parity will be the focus of the August lunch briefing by the House Working Group on Mental Illness. House members will get to vote at some point on a comprehensive parity bill (HR 162) that Roukema introduced in January. ■

Autism

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ples for five different brain proteins—nerve growth factor, substance P, brain-derived neurotrophic factor, calcitonin gene-related peptide, and vasoactive intestinal peptide.

They found comparable amounts of nerve growth factor and substance P in blood samples from all four groups of subjects. However, they found much higher levels of the other three proteins in blood taken from subjects with autism and with mental retardation than in blood taken from the cerebral palsy subjects and healthy controls. And what was especially intriguing is that while about a quarter of the autism subjects did not develop symptoms of autism until they were at least 1 year old, they already had large amounts of these three proteins at birth.

Thus the three proteins may well play causative roles in autism, Nelson and her team concluded, and they believe their findings also suggest that autism is already present at birth or maybe even before. Some other evidence, in fact, also implies that this is the case, she pointed out.

For instance, if mouse-embryo brains are exposed to vasoactive intestinal peptide,