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PSYCHIATRIC NEWS

"see" references appear on pages 12,

Darrel Regier, M.D., M.P.H., director of APA's American Psychiatric Institute for Research and Education, answers questions from a House of Representatives subcommittee on health as insurance and business representatives listen intently. At times the exchanges between subcommittee members and antiparity witnesses were harsh. See story below.

APA Parity Testimony Gets Positive Reception on Hill

APA testimony helps cement support for mental health parity from a key House subcommittee considering the Roukema-Kennedy bill. Chances for passing parity this year may hinge on dwindling time.

Government News

BY JIM ROSACK

Compelling testimony by APA's Darrel Regier, M.D., M.P.H., helped cement the support of the House Energy and Commerce Subcommittee on Health last month in the legislative battle to pass the Mental Health Equitable Treatment Act of 2002 (HR 4066). The bill was introduced earlier this year by Reps. Marge Roukema (R-N.J.) and Patrick Kennedy (D-R.I.).

HR 4066 has 240 cosponsors in the House, and its Senate companion, S 543, introduced by Sens. Paul Wellstone (D-Minn.) and Pete Domenici (R-N.M.), passed that chamber last year with more than 65 cosponsors.

In April President Bush urged Congress to send him a parity bill to sign by the end of this legislative session (*Psychiatric News*, May 17). The House bill is being considered by the Energy and Commerce Committee, as well as the Committee on Education and the Workforce. The latter committee held hearings on the bill in March (*Psychiatric News*, April 19).

Last month's three-and-a-half-hour hearing was opened by Health Subcommittee Chair Rep. Michael Bilirakis (R-Fla.), acknowledging that the key arguments expressed by parity opponents center on the high cost of covering all mental illnesses specified in *DSM-IV-TR*, as would be required under the language of the proposed legislation.

"I do believe that some mental conditions, just like some physical conditions, do not warrant equal treatment by a health plan," Bilirakis said. "However, I want to be clear on this issue—I think that serious mental illness is a problem that deserves serious attention. But I also think we need to be careful with our limited health care resources."

Bilirakis then challenged the witnesses invited to testify to present information that would help the subcommittee members reach agreement on the issues of cost and extent of coverage—whether parity should be limited to only "serious mental illness" or available for coverage of all *DSM-IV-TR* disorders.

In their opening comments, Rep. Charles Norwood (R-Ga.) called the parity legislation "a reasonable approach," and Rep. Sherrod Brown (D-Ohio) termed it "an effective compromise responsive to the concerns of employers," noting that "there's a big differ-

please see ***Parity*** *on page 24*

Government News

Governors Seek Federal Remedy For Growing Medicaid Crisis

Governors ask for federal Medicaid relief as declining tax revenues threaten the viability of public mental health services.

BY KATE MULLIGAN

The 94th Annual Meeting of the National Governors Association (NGA) last month was dominated by concerns about fiscal issues—most specifically, Medicaid.

Outgoing NGA Chair John Engler (R-Mich.) said in a press statement, "For the past year, the governors have been in the unfamiliar territory of declining tax revenues, spiraling health care costs, and a slowing economy."

In the same statement, he laid out the issues that dominated the agenda for the meeting: increasing the federal share of Medicaid costs, improving access to prescription drugs, welfare reform, and homeland security.

The July 15 *New York Times* reported that 45 states claimed revenue shortfalls over the last year totaling $50 billion, caused by a drop in sales, capital gains, and corporate and personal income taxes.

According to NGA background materials, Medicaid comprises an average of 20 percent of state spending. Costs of the program have grown in both absolute and relative terms in recent years. As a result, Medicaid is the second-largest expenditure in most state budgets.

Medicaid is the largest public source of funds for mental health services.

The *New York Times* also reported that "the most aggravating problem" with Medicaid is that increasing numbers of dually eligible people are moving from Medicare to Medicaid, effectively transferring more costs to the states.

About 7 million seniors are considered dually eligible, and their health expenses account for 35 percent of the cost of Medicaid.

The NGA has proposed measures to provide federal fiscal relief for states in terms of Medicaid.

The first proposal has three components: a temporary increase in states' Federal Medical Assistance Percentage (FMAP), flexible health and social services grants allocated on the basis of states' shares of Medicaid FMAP, and funding for a one-year "hold-harmless" provision for states that experienced a

please see ***Medicaid*** *on page 20*

Better Access to Geriatric MH Care Goal of New House Bill

Government News

Newly proposed legislation would open the doors of senior citizen centers to psychiatrists and mental health professionals to ensure that older Americans receive quality psychiatric care.

BY EVE BENDER

In an attempt to bridge the gap between untreated mental illness in older Americans and the services that can dramatically improve their quality of life, Rep. Patrick Kennedy (D-R.I.) introduced the Positive Aging Act of 2002.

During a July 1 visit to the Cumberland Senior Center in Cumberland, R.I., Kennedy, a longtime Congressional champion of better mental health care, announced the new legislation. It is designed to promote geriatric mental health outreach services and integrate mental health screening and services into primary care settings.

"Disability due to mental illness in our elderly population is rapidly becoming a major public health dilemma," Kennedy said at the senior center. "This legislation will enable seniors to receive mental health services in the health care facilities they are most familiar with."

Kennedy introduced the Positive Aging Act of 2002 (HR 5077) in the House of Representatives. The bill was then referred to the House Committee on Energy and Commerce, which has not yet taken action on it.

The legislation would provide mental health screenings, referrals for follow-up care and consultations, and the use of evidence-based medicine for the treatment of mental health disorders in primary care settings.

The legislation also includes a component for the education of primary care clinicians on mental health issues.

In addition, the act would provide funding for mental health outreach teams to travel to the primary care facilities and nursing homes to provide treatment. According to the bill, despite the fact that "on average, a quarter of all patients seen in primary care settings have a mental illness, primary care practitioners identify such illness in only about half of these cases."

The bill does not specify how much money should be appropriated to provide the services specified but instead asks that funding be provided "as necessary."

Kennedy sought and received expertise about how to keep seniors with mental illness from ending up in hospitals and other institutions. In doing so, he collaborated with the American Association for Geriatric Psychiatry and, in particular, Gary Kennedy, M.D., who is president of that organization. The two men are not related.

"It is very rare when science drives policy, but here it is the impetus behind the legislation," Gary Kennedy told *Psychiatric News*. For instance, mounting evidence shows that integrating mental health services with general medical services produces improved mental health outcomes, he noted.

"The idea behind this legislation is to have psychiatrists and mental health professionals work with the seniors where they are most likely to be found—in the primary care setting, senior citizen centers, and retirement communities," he said.

Rep. Kennedy's legislation would authorize the Substance Abuse and Mental Health Services Administration (SAMHSA) and its parent agency, the Department of Health and Human Services, to carry out certain aspects of the legislation. Specifically, the legislation would do the following:

- Authorize SAMHSA to integrate screening and mental health treatment services at primary care sites that serve geriatric populations.
- Authorize a new SAMHSA grant program to support geriatric mental health outreach teams in settings where seniors live or receive social services.

please see ***Geriatric Care*** *on page 5*

HIPAA Help

The HIPAA privacy rule enforcement date is April 2003. To help members understand and comply with the rule, APA has developed educational information posted on its Web site at <www.psych.org/pub_pol_adv/hipaa/index.cfm>. Among the items are "Guidelines for Minimum Necessary Disclosures to Third Party Payers for Psychiatric Treatment," "Psychotherapy Notes Provision of HIPAA Privacy Rule," and "Documentation of Psychotherapy by Psychiatrists." Members who do not have Internet access may request copies from Linda Hughes at (202) 682-6227. APA's Committee on Confidentiality will continue to develop materials for this Web site, according to chair Margo Goldman, M.D.

Note that the deadline to request an extension to comply with the electronic transaction standards for filing Medicare claims is ***October 15.*** More information on the electronic transaction regulation is posted on the APA Web site at <www.psych.org/pub_pol_adv/hipaa/transact_reg.cfm>.

from the president

Chance to Make a Difference

BY PAUL APPELBAUM, M.D.

This past spring, President Bush announced the creation of a new commission to assess the current state of mental health services in the United States and to make recommendations for improvement. The members of the somewhat grandiloquently named President's New Freedom Commission on Mental Health were appointed over the subsequent months, and the group has now begun its work. At a time of growing threats to the integrity of mental health services, this is too important an opportunity to waste.

Michael Hogan, Ph.D., the mental health commissioner in Ohio, chairs the commission, which has a highly diverse membership. President Bush has given the group only one year of life; its report is due by next spring, after which it will go out of existence. This is an extremely aggressive timetable for a body that is being asked to address a complex area that spans the public and private sectors. Perhaps most problematic of all, the commission reportedly has been told that whatever recommendations it makes ought not to involve major new expenditures of resources.

APA was invited to testify at the commission's first public hearing, where we were ably represented by Darrel Regier, M.D., M.P.H., director of the American Psychiatric Institute for Research and Education (APIRE) and one of the country's leading experts on the mental health service system. He pointed to seven barriers to persons with mental disorders obtaining adequate treatment:

- Failure to recognize mental disorders
- Failure to access treatment due to stigma
- Inability to pay for available treatment
- Inadequate treatment resources in some areas
- Inadequate insurance coverage—lack of parity-level benefits
- Inadequate resources and organization of care in the public sector
- Lack of coordination of public and private sectors of care

As Dr. Regier correctly said, "Reducing the remaining barriers to care depends primarily on a new commitment of the American people and their government to enact policy changes that address the financing and organization of mental health care in both the private and public sectors."

Why is this such a crucial time for the commission to be undertaking its work? The last decade, as we all know, has seen a growing gap between the resources available for psychiatric treatment and the needs of our patients. Public sector pro-

please see ***From the President*** *on page 27*

Vermont Gives Formulary Exemption To Psychiatric Drugs

Psychiatrists and other Vermont advocates unite to win an exemption from the state's Medicaid drug formulary for medications used to treat mental illness.

BY KATE MULLIGAN

In June Vermont enacted legislation designed to contain the costs of prescription drugs and increase access to those drugs through use of a preferred drug list and other means. It applies to the Medicaid program and various other state programs for low-income people and other groups.

A key element of the bill (Act Relating to Prescription Drug Cost Containment and Affordable Access, H 31) stipulates that the "prior authorization process shall not apply to prescription drugs prescribed for the treatment of severe and persistent mental illness including schizophrenia, severe depression, or bipolar disorder."

Combined Efforts

David Fassler, M.D., the representative for state and federal legislation of the Vermont Psychiatric Association (VPA) and an APA trustee, told *Psychiatric News* that the exemption and other safeguards in the legislation came about because of the combined efforts of VPA, the Vermont Medical Society, and other advocacy groups such as the Alliance for the Mentally Ill of Vermont.

"Acting on our own, this level of success would have been almost impossible," he said.

The associations also were able to defeat a provision that would have allowed pharmacists discretion to substitute drugs for those prescribed.

Fassler said the groups are working to ensure that the exemption covers all prescription drugs necessary to treat mental illness.

Cheryl Rivers, executive director of the Northeast Legislative Association on Prescription Drug Prices, told *Psychiatric News*, "The Vermont legislature was able to support that exemption because we know it's tough to get medications right with mental illness. We understand, for example, that the change in the color of a pill can affect a patient."

Rivers, who is a former chair of the Senate Finance Committee in Vermont, did not rule out the possibility that the exemption might be eliminated in the future.

Other Safeguards

The law contains other important safeguards. For example, in cases where prior authorization is required, prescribers for a patient with an emergency condition must receive a response within four hours from the time the program or participating health plan receives the request.

In addition, the legislation stipulates several activities to help the state evaluate the effectiveness of the law.

A state official must submit a report to appropriate legislative committees each year, including an assessment of administrative costs relating to prescription drug benefits, costs and savings of the pharmacy benefit manager (PBM) contract, and recommendations for improving the effectiveness of the contract.

The state will not enter into a contract with a PBM unless the PBM agrees to disclose any agreement to favor the products when the Florida legislature established a preferred drug list that consisted of drugs for which manufacturers grant supplemental rebates of 10 percent. Drugs used to treat mental illness and HIV are exempt from the legislation (*Psychiatric News*, March 1).

Since then, Michigan has established a formulary that requires authorization from a "state technician" if a drug is not on the list. Drugs used to treat mental illness are not exempt (*Psychiatric News*, January 18, April 19, August 2).

Indiana, Minnesota, Kansas, and Ohio have passed legislation related to Medicaid drug formularies providing full or partial protections for drugs used to treat mental illness.

In a related action, the U.S. Senate voted on July 18 to approve a measure that would allow states to use the purchasing power of their Medicaid programs to negotiate prescription drug discounts for residents who would not otherwise qualify for Medicaid.

"Acting on our own, this level of success would have been almost impossible."

The measure is an amendment to the Greater Access to Affordable Pharmaceuticals Act of 2001 (S 812), a bill that addresses several prescription drug issues, including a Medicare drug benefit.

According to the July 19 *Wall Street Journal*, the measure would allow states to negotiate larger discounts than the Medicaid law requires and add prescription drug formularies to their Medicaid programs.

The Pharmaceutical Research and Man-

please see ***Vermont*** *on facing page*

Congress on Way to Passing NIH Research Increase

APA praises the Senate Labor-HHS Appropriations Subcommittee for passing the $3.7 billion increase for the NIH budget it sought for Fiscal 2003.

BY CHRISTINE LEHMANN

APA's goal of having the government double the National Institutes of Health budget between 1998 and 2003 passed another legislative hurdle last month.

The Senate Labor-HHS Appropriations Subcommittee approved the Bush administration's request to increase the NIH budget by $3.7 billion (approximately 15 percent) in Fiscal 2003. That brings the total NIH budget to $27.2 billion in Fiscal 2003, which is double the Fiscal 1998 spending level.

APA praised subcommittee Chair Tom Harkin (D-Iowa) and ranking minority member Arlen Specter (R-Pa.) for "their commitment to increased federal funding of biomedical and behavioral research at the NIH."

Harkin said in a press release, "Five years ago, Senator Specter and I set out to double funding for our nation's finest medical research facilities. Today—without regard to administration or party—we have reached that goal, increasing our nation's investment in the lifesaving research supported by NIH to $27.2 billion."

President George W. Bush proposed the approximately 15 percent increase for NIH in his Fiscal 2003 budget to Congress in February, but the percentage requested for some of the individual institutes was less (*Psychiatric News*, March 1). APA's Academic Consortium supports the president's NIH budget request, but urged Congress in March to give each mental health–related institute the same increase of 15 percent in Fiscal 2003.

"This is the first year that a president has not given all the institutes the same increase," said consortium cochair Lewis Judd, M.D. (*Psychiatric News*, April 16).

The Senate appropriations subcommittee instead approved the president's budget request of a 9 percent increase for the National Institute on Drug Abuse ($80 million) and the National Institute on Alcohol Abuse and Alcoholism ($34 million) in Fiscal 2003, according to Lizbet Boroughs, an associate director of APA's Division of Government Relations.

The National Institute of Mental Health fared somewhat better in the dollar amount, with a budget increase of $103 million in Fiscal 2003. However, this represents only an 8 percent increase above last year's funding level, according to Boroughs.

The Labor-HHS spending measure has to be approved by the Senate Appropriations Committee and the full Senate. The House of Representatives is not likely to take up its companion spending measure until the fall, said Boroughs. ■

Vermont

continued from facing page

ufacturers of America (PhRMA) has filed suit to stop similar prescription drug-discount programs enacted in various states. PhRMA President Alan Holmer is quoted in the July 19 *Wall Street Journal* as saying that the measure would "put state bureaucrats, not doctors, in charge of medical decisions for Medicaid patients and would force Medicaid patients to the back of the line when it comes to state-of-the-art medicine."

The text of Vermont's HR 31, An Act Relating to Prescription Drug Cost Containment and Affordable Access, is posted on the Web at <www.leg.state.vt.us/docs/2002/acts/ACT127.HTM>. The text of the Greater Access to Affordable Pharmaceuticals Act of 2001 can be accessed at <http://thomas.loc.gov> by searching on the bill number, S 812. ■

Geriatric Care

continued from page 2

- Foster collaborations between mental health professionals and senior centers, adult day-care programs, and assisted-living facilities.
- Establish a new deputy director for geriatric mental health services within the Center for Mental Health Services (CMHS) to develop and implement initiatives that address the mental health needs of older Americans.
- Create positions on the advisory council of CMHS for older Americans, their families, and geriatric health specialists.

The Positive Aging Act of 2002 is an outgrowth of the Positive Aging Project, which Kennedy established in February to help seniors living in Rhode Island. Kennedy obtained a $935,000 federal appropriation to enable Landmark Medical Center in Woonsocket, R.I., to launch the program.

The project, which is housed in the Community Resource Center at Landmark's Senior Health Center, provides education, screening, and treatment for disorders that occur often in older adults and the emotional distress that often accompanies these diagnoses.

The text of the Positive Aging Act of 2002 can be accessed on the Web at <http://thomas.loc.gov> by searching on the bill number, HR 5077. ■

Unsolicited Prozac Prompts Florida Investigation

Walgreens, Eli Lilly and Co., and four health care professionals were subpoenaed by the Florida attorney general last month in another investigation involving the alleged misuse of private health information.

BY CHRISTINE LEHMANN

A Walgreens customer in Fort Lauderdale, Fla., became distraught in April after she received a free, unsolicited month's supply of Prozac Weekly in the mail along with a letter from her physicians endorsing the medication. The woman sued Walgreens Co., Prozac manufacturer Eli Lilly and Co., and her doctors for invasion of privacy. She also charged her doctors with malpractice.

Florida Attorney General Bob Butterworth is investigating how widespread the Prozac Weekly mailing was and whether any Florida laws, including the Deceptive and Unfair Trade Practices Act and the Medical Practices Act, were violated. Federal law also prohibits the dispensing of prescription drugs without a prescription. The attorney general will also determine whether the health professionals who were handling the woman's care—two internal medicine physicians and a physician assistant, along with a family practice physician at Holy Cross Hospital in Fort Lauderdale—are guilty of violating the state's medical practice law.

> **"This type of activity raises serious questions in the areas of both public health and marketing."**

"This type of activity raises serious questions in the areas of both public health and marketing," Butterworth said in a press release. "Physicians and pharmacists exploiting their relationship with patients to market drugs for big pharmaceutical manufacturers and pharmacy companies is also a troubling potential violation of Florida law. Of all people, patients should be able to trust their physician and pharmacist to have only the patient's health in mind when prescribing and recommending medication."

"The law protects patient confidentiality and requires physicians to examine and evaluate a patient's current needs before prescribing drugs," said Butterworth in the statement.

Psychiatrist and APA Trustee David Fassler, M.D., wrote in a letter to the editor published in the July 10 *New York Times* that the mailing incident "highlights the continuing erosion of privacy and patient confidentiality in our nation's health care system. Pharmacies, pharmaceutical companies, and physicians should never access or use identifiable clinical information about specific patients for commercial or marketing purposes."

Walgreens is the second-largest national retail drugstore chain in the nation.

In a press statement, Lilly called the Prozac mailing an isolated incident that is "inconsistent with Lilly policy."

"While Lilly supports informing people about new treatment options and encouraging them to discuss these options with their doctor, what occurred in Florida appears to go beyond this," according to the statement.

Lilly promised to conduct a thorough investigation of the Florida incident and take appropriate action. "We understand why people would be concerned about receiving unsolicited prescriptions in the mail. To the extent Lilly personnel participated, Lilly apologizes to those patients affected by it," Lilly said.

Crystal Wright, vice president of media relations at the National Association of Chain Drug Stores, agreed with Lilly that the mailing of Prozac Weekly in Florida was an isolated incident.

"Pharmacies commonly send advisories to patients about new brand-name or cheaper generic drugs that may be related to the patient's illness and reminders to refill prescriptions," said Wright.

She emphasized that pharmacy communications are supposed to indicate whether they are funded by drug companies and that drug companies do not see patients' medical records.

Walgreens and Savon Drugs send out pharmacy letters to patients, while Rite-Aid sends patients advisories on generics and brand-name drugs, according to the June 11 *Washington Post*. CVS said it sends only refill reminders to patients.

The Bush administration would allow pharmacies to mail marketing letters to patients without their prior authorization under proposed changes to the privacy rule of the Health Insurance Portability and Accountability Act. The privacy rule is slated to take effect next April (*Psychiatric News*, May 3; see box on page 2).

"Patient education, patient compliance, disease management, and wellness programs are not defined as marketing activities in the revised rule," said Joanne Hustead, senior counsel at the Health Privacy Project at Georgetown University in Washington, D.C., in an interview.

APA has called on the Bush administration to eliminate these marketing provisions. Without their elimination and a requirement that patients are told how to "opt out"of receiving drug-marketing letters, the protections are meaningless, said Hustead.

"Walgreens' dispensing of drugs through the mail was most likely an isolated incident, but we are concerned that more egregious practices by pharmacies and drug companies will occur if the proposed federal changes are adopted," said Hustead.

A press release describing the Prozac mailing investigation by the Florida attorney general can be accessed at <http://legal.firn.edu> by clicking on "Subpoenas issued to determine whether unsolicited Prozac mailing violated Florida law." ■

Mentally Ill Workers Rarely Prevail in ADA Discrimination Claims, Survey Finds

The ADA's requirements and definition of disability make it difficult for people with mental illness to win ADA claims.

BY KEN HAUSMAN

Workers who have a disability, especially those with mental illness or substance abuse disorders, have little chance of prevailing when they file employment discrimination cases against their employer.

In its fifth annual survey of such cases brought under the ADA, the American Bar Association's *Disability Law Reporter* found that employers won nearly 96 percent of discrimination cases filed in courts and 73 percent of cases filed as administrative complaints with the federal Equal Employment Opportunity Commission (EEOC).

The survey, whose results are reported in the May-June issue of *Mental and Physical Disability Law Reporter*, examined the outcomes of 429 cases that were decided in 2001. Of these, employers emerged victorious in 314 cases, while employees won just 14 of the claims. In the remaining 101 cases charging disability discrimination, the claims' merits were not decided, often because the EEOC decided complainants were not eligible to sue under the terms of the ADA.

A total of 86 of the 429 cases involved mental illness, substance abuse, or a combination of the two, the researchers noted. The chances of an employee prevailing in an ADA-related case involving these disorders are slim to none, they found. For example, of the 70 cases in which the disability was attributed to mental illness, the employee won once, while employers won 54 cases. (There was no resolution in the rest of the cases. Also, it is not known how many employees are successful in getting accommodations from their employers and thus have no need to file claims or suits.)

No Victories in 2001

In the 13 substance abuse claims, employees had no victories in 2001, and the same result turned up in the three cases involving comorbid mental illness and substance abuse.

The researchers pointed out that the "largest category of case decisions are those in which employers prevailed summarily, without the merits of the employees' claims ever being considered."

They blame this situation in large part on the ADA's complex procedural and technical requirements, which, they noted, create "difficult obstacles for plaintiffs to overcome." These obstacles include "satisfying the requirement that the plaintiff meet the ADA's restrictive definition of disability—a physical or mental impairment that substantially limits a major life activity, a record of such an impairment, or being regarded as having such an impairment—and still be qualified to perform essential job functions with or without reasonable accommodation."

In addition, the functional assessment of the worker's disability must evaluate whether it is corrected or correctable through medications or other measures, such as prosthetic devices or therapies, that mitigate the severity of the impairment's functional consequences.

Psychiatrist Marcia Scott, M.D., cochair of the APA Committee on Psychiatry in the Workplace and a disability expert, stressed in an interview with *Psychiatric News*, however, that in the minds of the law's framers, "the purpose of the ADA was to get those who had pervasive problems into the workforce and keep them there. The purpose was not to adjudicate the problems of worker-employer relationships or those caused by temporary illness, which are clearly covered by disability benefits" rather than the ADA.

She pointed out as well that to be eligible for protection under the ADA, the person's limitations must extend to functions beyond just work.

Scott suggested that having an illness, such as depression, bipolar disorder, panic disorder, or even PTSD, that is characterized by occasional recurrences and remissions "is not the same as being pervasively disabled, even at baseline. These people don't need the ADA. They need benefits when they are too sick to work and physician help returning to work," she asserted. The law was not meant to cover temporary medical conditions or exacerbations of illnesses, even if those flare-ups could be considered a disability. And an employee must be able to do the essential function of his or her job to be eligible for ADA provisions, not necessarily every function, Scott added.

Scope of Act Clarified

The U.S. Supreme Court clarified the scope of the ADA this year when it ruled in a case against Toyota Motor Manufacturing that to qualify for ADA protections, a worker's disability must be "permanent or long term."

"No one believed the ADA would do much for the severely mentally disabled, even though they hoped it would," said Scott. "The accommodations advocated for the severely mentally disabled are often unrealistic for an employer and tend to stigmatize the employee—things such as high walls, extreme quiet, not working with others. The accommodations that best serve workers with a chronic, disabling mental condition are access to additional treatments, supportive treatments, a limited but well-structured job, and sometimes direct supervision."

Despite the marked lack of success in getting legal redress for ADA-based claims, Jennifer Mathis, an attorney and ADA expert with the Judge David Bazelon Center for Mental Health Law, said she hopes people with mental illness or substance abuse disabilities do not become so discouraged by these data that they fail to file complaints when they feel they are victims of disability discrimination.

Mathis explained to *Psychiatric News* why it is so difficult for employers and mentally disabled workers to agree on remedies that would avoid ADA-related legal claims—and why such workers have a hard time convincing courts that an employer has violated the ADA.

please see ***ADA Claims*** *on facing page*

Drug Chain Customers Can Invoke Protection From Marketers

A national drugstore chain says that it will change how its pharmacies handle customers' medical information for marketing purposes to better protect their privacy.

BY CHRISTINE LEHMANN

Patients who purchase their prescriptions at Eckerd drugstores will be asked whether they want their private health information used for marketing purposes.

That was one of several changes Eckerd, headquartered in Clearwater, Fla., agreed to make to settle a six-month investigation by the Florida attorney general into its patient privacy policies.

"It is especially fitting that the endowment from Eckerd be used to provide ethics training for future pharmacists."

According to Eckerd, the chain owns approximately 2,640 drugstores in 20 states and employs more than 8,000 pharmacists.

The drugstore chain and the attorney general announced the settlement last month in Tallahassee, Fla., in which Eckerd agreed to the following conditions, according to the attorney general's office:

- Refrain from using prescription pickup logs or forms to obtain customer authorization for the use of medical information for marketing purposes.
- Restrict direct marketing of prescription drugs to customers who have provided written consent to use their medical information for such purposes.
- Advise customers what type of medical information will be disclosed and to whom.
- Disclose in a written communication who wrote and is paying for communications to customers.
- Provide in every communication the company sends to customers a free and easy way to withdraw consent to receive such communications.

Eckerd also donated $1 million to endow an ethics chair in the school of pharmacy at Florida A&M University, according to the release.

"It is especially fitting that the endowment from Eckerd be used to provide ethics training for future pharmacists," said Florida Attorney General Bob Butterworth in the release. "The primary concern of a pharmacist should be the safe and effective treatment of patients, not marketing opportunities."

Butterworth initiated the investigation last December after John Newton, an assistant, discovered his signature on a prescription receipt log giving the drug chain permission to use his private information for marketing purposes.

"The fine print on a form certifying that the patient had the opportunity to receive medication counseling did not adequately inform customers that they would have their personal information used for commercial purposes," said Butterworth in the release.

A patient could "opt out" by notifying a pharmacy technician; however, the attorney general's office found that two pharmacy technicians at one Eckerd's drugstore were unaware of the "opt-out" procedures, according to the case file.

"We cooperated fully with the attorney general's office and are pleased to amicably resolve this matter. The changes we have agreed to make to address the attorney general's concerns put us at the forefront of the industry in the way we handle these programs," said Jerry Thompson, senior vice president/pharmacy services at Eckerd's, in a press release.

Thompson noted that the investigation did not find any evidence that Eckerd had improperly shared confidential patient information.

The corporation sold more than 100 marketing contracts to drug companies last year for which it received $1.9 million. In addition, the attorney general's office found that drug companies were using patients' medical information to urge them to switch from patent-expired drugs to medications still within their patent period, according to a July 12 *Palm Beach Post* article.

The Eckerd settlement can be accessed on the Web site of the Florida attorney general's office at <http://legal.firn.edu/> by clicking on the news release titled "Eckerd endows $1 million ethics chair at FAMU. . . ." ■

ADA Claims

continued from facing page

For example, "many of the accommodations needed by individuals with mental illnesses, while they are not expensive, are not as simple for employers to understand and to do as are accommodations" for other conditions, she said. "Accommodating someone with a mental illness may require some flexibility and entail trying different things to see what works, such as flexible scheduling, leave time, working at home, or eliminating marginal job duties."

She added, "Plaintiffs with mental illnesses often lose cases because it appears [to the court or EEOC] that the employer made some effort to accommodate them, even though the accommodations tried were really not effective."

The process of achieving a solution that satisfies the employer and the worker is often so difficult, and stigma so deeply rooted, that the result turns out to be "bad blood between employer and employee," Mathis explained, "leading agencies and courts to conclude that an employee was let go not based on prejudice, but simply based on a personality conflict."

Scott cautioned, however, that "a reasonable accommodation isn't a job with no stress. The ADA is not relapse prevention. If workers can't do the essential functions of their job, they need another job," and psychiatrists can play an important role in helping patients realize this. ■

First Jeanne Spurlock Fellow Leaves Mark on Capitol Hill

Last year Susan Ishiyama, M.D., used her skills to treat psychiatrically ill children. This year she applied those skills to the legislative process on Capitol Hill.

BY KEN HAUSMAN

Psychiatry resident Susan Ishiyama, M.D., and Rep. Patrick Kennedy (D-R.I.) turn out to be an excellent match. Both have an abiding interest in improving the state of children's mental health care.

As a result, Kennedy, who is one of the strongest backers of mental health care parity in Congress, agreed to offer Ishiyama a post as a Congressional fellow in his office.

Ishiyama just finished her six-month Capitol Hill tenure as the 2002 APA/AACAP Jeanne Spurlock Congressional Fellow. (AACAP is the American Academy of Child and Adolescent Psychiatry.)

Ishiyama, who recently completed a child and adolescent psychiatry residency at Pittsburgh's Western Psychiatric Institute and Clinic, was assigned to work on several pieces of legislation on which Kennedy and his staff are involved. These, she said, include bills related to post-disaster mental health services, substance abuse education for health professionals, expanding an existing law on child mental health services, and insurance parity.

The child mental health care expansion legislation has consumed the largest portion of her time on the Hill, she noted. "I have spent a considerable amount of time on it, reworking and adding things that I felt needed to be included—issues such as extending the period, currently four years, during which Medicare will pay the salary of child psychiatry residents and fellows. After four years, the residency program must pay their salary, making training child psychiatrists costly for the programs."

She added that her work on this bill has also involved contacting advocacy and professional organizations, meetings with other parties who have an interest in such legislation, and approaching other House of Representatives members to be cosponsors of Kennedy's bill. "It has been quite a learning experience," said Ishiyama.

She explained that in addition to her work on mental health issues, Kennedy and his staff had her meet with other medical and health-related groups as part of their ongoing contacts with those constituencies. The goal of these meetings was to learn what issues they wanted the congressman to be aware of. Noting that among the organizations with which she met were the American College of Obstetrics and Gynecology and the Funeral Directors Association, Ishiyama commented that she "covered areas ranging from birth to death."

Speech writing was also on her agenda, and she noted that she drafted speeches for Kennedy on several topics related to mental health concerns.

Susan Ishiyama, M.D.: APA's Spurlock Fellowship is "an outstanding experience, especially if one is interested in public health policy and the working of the U.S. government."

"I was fortunate," she said, "to be able to work directly with the congressman on certain issues and to work extensively with senior staff on others."

One negative aspect of the fellowship is its short length, Ishiyama said. The fellowship is ending, she noted, "just as I am gaining some momentum, especially on the child mental health bill, and I hate leaving things unfinished." She urged APA and AACAP to find a way to extend the fellowship from six to at least 10 months.

She also suggested that a structured orientation for new fellows prior to their stint on Capitol Hill would enhance the experience as would more interactions with APA and AACAP during the fellowship.

"All in all, this was an outstanding experience," she emphasized, "especially if one is interested in public health policy and the working of the U.S. government." She added that she "would jump at the chance to do something like this again if the opportunity ever presented itself."

Ishiyama is the first winner of the Jeanne Spurlock Congressional Fellowship, which is named in honor of the late APA deputy medical director and head of its Office of Minority and National Affairs. As befits a fellowship named for a psychiatrist who was a forceful advocate for children's mental health issues, its intent is to provide general or child psychiatry residents an opportunity to work in the office of a member of Congress or a congressional committee whose agenda includes child and minority health issues. APA and the American Psychiatric Foundation administer the fellowship in collaboration with AACAP.

The fellowship is open to psychiatry residents who are in their second or third year of training or who will be out of training for less than one year during their fellowship experience. Each fellow receives a $20,000 stipend and $2,500 to cover expenses of moving to Washington, D.C.

More information about the Spurlock fellowship is available on APA's Web site at <www.psych.org/med_ed/spurlock_congressionalupdate111401.pdf> or from Marilyn King at (202) 682-6096. ■

Irish M.D. Finds Home In Psychiatry and the U.S.

Psychiatrist John O'Reardon, M.D., may have had the luck of the Irish in being able to emigrate to the United States. But it is depressed Americans who now have the luck as they profit from his clinical and research skills.

BY JOAN AREHART-TREICHEL

John O'Reardon, M.D., a native of County Kerry, Ireland, sits in his small, cozy office on the third floor of 3535 Market Street in Philadelphia and smiles an impish smile. Yes, he does have an Irish tale to tell—how he has come from milking cows in Ireland to banishing refractory depression with the use of a magnet on Philadelphia's "Avenue of Technology," as Market Street is nicknamed.

John O'Reardon, M.D. finds helping people with treatment-resistant depression "immensely rewarding because they have been suffering for a long time."

"I was born in County Kerry, Ireland, in—oh dear, maybe it's encroaching middle-aged vanity, but can you fudge it?" He chuckles while wisps of prematurely graying hair rise above his high forehead.

"My two brothers and I had to milk the cows every morning, harvest the hay, and otherwise work hard manually," he continues, "but our father, a part-time farmer and office worker, and our mother, a homemaker, heavily emphasized education for us boys as well, because in Ireland, as in many parts of the world, your ticket to future economic prosperity rests heavily on your education."

In fact, one of O'Reardon's brothers became a teacher, the other became a manager of a company, and John decided to become a physician—the first member of his family to do so. He attended medical school at University College Cork, graduated in 1984, and worked as a primary care physician. As time went on, he became increasingly interested in psychiatry.

"Really, some of it was the nature of primary care itself," he explains, "where you see a lot of psychiatric problems, often presented psychosomatically. And primary care shares with psychiatry the continuity of care where you see people long term or within families."

So in 1989 O'Reardon decided to start training in psychiatry. He went to London and worked at the Godden Green Clinic, a private psychiatric hospital. He also got trained in cognitive analytical therapy. This is a type of therapy, well established in Britain, that integrates cognitive and psychodynamic approaches in a brief psychotherapy. By 1993 he was a psychiatrist, as well as a primary care physician.

America Beckons

Around this time, both O'Reardon and his wife, a physical therapist, became interested in emigrating to the United States. One reason O'Reardon found the idea appealing, he says as he gesticulates to make the point, is that he was attracted to the United States for its diversity as well as for cultural and intellectual stimulation. Moreover, he says, he was thinking of devoting a good part of his future to psychiatric research, and he believed that research opportunities would be richer in the United States than in Ireland.

But there is a great chasm between wanting to emigrate to America and actually doing so, the O'Reardons were well aware. At that time, the U.S. Immigration and Naturalization Service offered visas through a lottery to 50,000 nationals from 19 countries around the world. But for their visa applications to be entered into the lottery, the applications had to be sent by surface mail and arrive on a specific day in Washington, D.C. However, that first year of the program, applicants were allowed to submit more than one application. So O'Reardon and his wife—"neither of us feeling that we were particularly lucky when it came to lotteries," O'Reardon recalls—mailed 1,000 applications each. "And the irony is that one of my wife's applications was selected from the lottery, whereas none of mine were," O'Reardon says with a smile. "So I qualified to come to the United States only on the basis of being her dependent."

O'Reardon experienced other difficulties as well. For instance, he recalls, "at the time that I applied for residency in the United States, which was 1993, the American Board of Psychiatry and Neurology recognized a PGY-1 year completed in internal medicine but not in family medicine, which was my primary care background. In our part of the world only family medicine is considered true primary care, and everything else is specialty. So because of this I had to do a PGY-1 year or internship. How much psychiatry I did was up for negotiation between me and the residency program director of whichever residency program I got into. I decided to do the full additional three years of residency (though I know some overseas colleagues who were able to shorten it by a year) as I wanted to get into the very best American program possible, that is, not cut any corners, and as I wanted to get the maximum possible out of my American training."

So O'Reardon did an internship and three years of residency at the University of Pennsylvania Medical School from 1993 to 1996. Then he did fellowships in psychopharmacology and cognitive therapy at the university. "I am what you might refer to as overtrained," he says good-naturedly.

It hasn't been all that easy getting established as an American psychiatric researcher, either, he concedes. "The biggest challenge for a young researcher is to find funding. How can you—as you finish your training and start to get research experience—support yourself in that interim period? Even a National Alliance for Research on Schizophrenia and Depression grant, which I have, would support you only one day a week for two years. So that means that you have to spend a lot of time on clinical work to support yourself, and while you are doing clinical work, you still have to generate hypotheses and pilot data that will get you to the point that some of the things you are researching are worth funding. And what's more, you don't have the support and staff that older scientists have."

Happy With His Decisions

Still, he says that he is happy with the decisions he has made—coming to the United States, repeating his psychiatric training, joining the University of Pennsylvania Medical School staff, and conducting psychiatric research, especially on treatment-resistant depression, at his Market Street office, which is home to a number of University of Pennsylvania psychiatric investigators.

O'Reardon holds the magnetic device that he uses when performing repetitive transcranial magnetic stimulation on his study subjects. He is hopeful that rTMS will soon win FDA approval as a treatment for refractory depression.

"All the research I do is clinically based," he says. "I really like patients."

For instance, one of the research areas in which he is engaged is repetitive transcranial magnetic stimulation (rTMS). Several groups of investigators have reported that rTMS, which consists of placing a magnetic coil over the left frontal scalp of a conscious patient to stimulate the dorsolateral prefrontal cortex of the brain, can banish treatment-resistant depression if it is given in 20-minute sessions, five days a week, for two to four weeks. In fact, the technique was approved as a treatment for treatment-resistant depression in Canada last year. If it is ultimately approved by the U.S. Food and Drug Administration, it will likely prove to be an attractive alternative to electroconvulsive therapy in many cases because, unlike ECT, it requires no anesthesia and is believed to cause no cognitive or memory difficulties. It would also be a viable alternative to medication because side effects are minimal—occasional mild headaches, no gastrointestinal symptoms, and, very crucially, no sexual dysfunction (which is a big negative for patients who stay on antidepressants over the long term).

O'Reardon is now studying rTMS in a group of patients with treatment-resistant depression. He leads his visitor

please see ***O'Reardon*** *on page 25*

'Imaginative and Intuitive'

To give APA members a glimpse into the life and challenges of an early career researcher, *Psychiatric News* spent an afternoon with John O'Reardon, M.D., on his home turf during APA's 2002 annual meeting in Philadelphia. O'Reardon came to *Psychiatric News's* attention as a grantee of the National Alliance for Research on Schizophrenia and Depression (NARSAD).

At first O'Reardon was somewhat uncomfortable about the request for an interview, but after he was told the purpose of the feature, he appeared to feel more at ease and graciously agreed to talk with a *Psychiatric News* reporter and show her his lab.

Two research colleagues with whom O'Reardon has collaborated agreed that O'Reardon has earned his turn in the spotlight: Albert Stunkard, M.D., a former chair of psychiatry at the University of Pennsylvania, and Moira Rynn, M.D., a child psychiatrist at the University of Pennsylvania.

"John is very imaginative, very intuitive, and enormously entrepreneurial," Stunkard explained in a phone interview. "He also gets to the point quickly, and he is able to work very fast. Since he has worked as a general practitioner in Ireland, he is also very good at handling general medical issues that come up in the course of seeing patients."

"Yes, John is very intuitive about what clinical questions need to be answered," Rynn agreed. "And he is expanding into an area that is very cutting edge—trying to find out how cognitive therapy affects the brains of severely depressed subjects in his imaging research. It is a fascinating area and very much needed. He is really one of the few people doing that."

APA's Education Director Leaves Stronger Division

After a distinguished tenure at APA, James W. Thompson, M.D., steps down as director of APA's educational programs to head up a new initiative at NIH.

James W. Thompson, M.D., M.P.H., has left his position as director of APA's Division of Education, Minority, and National Programs to take a position at the National Institutes of Health (NIH) as executive director of graduate medical education. His new position began August 1.

"My four-and-a-half years at APA have been stimulating and productive," said Thompson. "I've enjoyed working with the members, and particularly with the staff. I often say 'we' when speaking of things accomplished during my tenure at APA, because without our loyal and talented staff, I could not have accomplished nearly as much."

James Thompson, M.D., addresses APA staff in a farewell reception held in his honor. With him is a painting he was presented as a gift, "He Sings of His Horse" by Native American artist Parker Boyiddle. Thompson is a member of the Delaware tribe.

Said APA Medical Director Steven Mirin, M.D., "We are grateful to Jim Thompson for his leadership in expanding APA's array of continuing medical education programs while overseeing the development of policies and procedures to assure that our industry-supported educational programs remain of high quality and free of bias. We thank Jim for his contributions to APA and wish him every success in this new phase of his career."

Asked about his accomplishments at APA, Thompson first pointed to the continuing medical education (CME) program at APA. When he arrived, he indicated that CME was, except for APA's two annual meetings, very much a shoestring operation. "Now," Thompson said, "CME is a full department with several staff, and it produces a multitude of products for APA members."

He also noted APA's new CME Web site at <www.psych.org/cme/apacme/>, the Clinical Highlights CME products from the spring annual meeting *(Psychiatric News*, August 2), and a new self-assessment exam. This new exam will soon become part of APA's Lifelong Learning in Psychiatry family of educational materials, led by Associate Division Director Deborah Hales, M.D.

"Most of all," Thompson reported, "I'm pleased to say that we have greatly improved our procedures for reviewing and controlling commercially supported programs, such as the annual meeting industry-supported symposia. We're now seen as a model program in this area."

While at APA, Thompson also served as a member of the Accreditation Review Committee of the Accreditation Council for Continuing Medical Education (ACCME) and has become a nationally known figure in the CME world.

Thompson also pointed to the reorganization and repositioning of APA's education function at APA. "Five years ago, that office was a hodge-podge of various functions and was quite isolated," he opined. "Since that time, we've separated it into several different functional offices, added the Office of Career Development and Women's Programs, and improved the communication among the offices, other staff, and APA members."

Thompson indicated that nothing pleases him more than having a member brag about one of his staff. "It makes it all worthwhile," he indicated.

Thompson also expressed pleasure at the improved relationship over the last few years with outside organizations. "We've reached out to organizations like the American Association of Directors of Psychiatric Residency Training and Association of Directors of Medical Student Education in Psychiatry, the subspecialty organizations, the American Board of Psychiatry and Neurology, other medical societies, and medical student organizations." He indicated that such outreach has resulted in a number of collaborative projects that benefit APA members, such as resident and early career psychiatrist fellowships.

Minority and national affairs is an area in which Thompson feels that much has been accomplished during his tenure, but also much remains to be done.

"We succeeded in physically moving this office into the center of headquarters activity, upgraded it to a department, and added a high-level assistant to the director," said Thompson. "We were able to add and enhance several programs, including recruitment programs for minority medical students. This staff does more with less than any other group in the central office, but this is an area that needs to be upgraded still further, as it represents the majority of APA members," he noted.

Thompson has similar feelings about the Office of HIV/AIDS Psychiatry. "This is one of the most productive offices at APA, and it puts out very-high-quality products, including a curriculum, a Web site, and a practice guideline," he stated. "But we've been unable to add significantly to the resources available to this program."

Thompson pointed out that the AIDS Education Project is in the American Psychiatric Institute for Research and Education, of which he was director of education and career development.

The other offices in APA's education division include those devoted to ethics and the annual meetings. "In ethics, we're positioned to take a new educational direction that will be of great benefit to our members and our patients," he stated. "And what can you say about the staff of the Annual Meetings Department? They simply put on the best medical meetings in the world."

At NIH Thompson will oversee that in-

please see ***Thompson*** *on facing page*

Psychiatrists Give High Marks To 2002 Annual Meeting

Registrants once again sing the praises of this year's annual meeting, which had the second largest attendance in APA's history.

BY EVE BENDER

Despite waning attendance at medical meetings worldwide since the September 11 terrorist attacks, APA still knows how to draw a crowd. The 2002 annual meeting in Philadelphia topped all attendance expectations, attracting a near-record number of attendees, according to an evaluation report on the meeting.

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

"The Scientific Program Committee indicated that the data, particularly respondents' comments and suggestions, were very helpful in framing their plans for the 2003 annual meeting," said Debenham. That meeting will be held May 17 to 22 in San Francisco.

Attendance Breakdown

Of those who responded to the general evaluation survey, 97 percent "believed the quality of the annual meeting sessions to be excellent," and 98 percent "felt that the sessions met their educational objectives." In addition, 96 percent felt that the scientific symposia would help them practice psychiatry more effectively.

Total attendance at the meeting was 19,464, a figure surpassed only by that of the 2001 annual meeting in New Orleans (19,887). Of these, 27 percent, or 5,228, were exhibitors, staff, and media.

International attendance at the 2002 meeting was significantly lower than it was at last year's meeting in New Orleans. While 4,279 international registrants participated in this year's meeting, 2,000 more attended last year's meeting. International attendance will be monitored over the next few years to determine whether the lower participation is a one-time phenomenon or a long-term trend.

In addition to Canada, which led the international contingent with 726 registrants, countries represented by more than 150 registrants included the United Kingdom (302), France (260), Mexico (202), Denmark (172), and Italy (168).

The turnout of media at the meeting pleased organizers—287 reporters and producers from approximately 115 media organizations registered in APA's press office, including 23 from outside the United States.

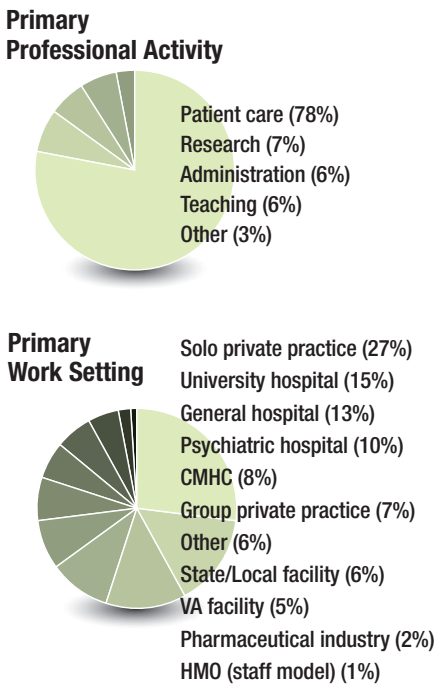
Industry-Supported Symposia

APA utilized a variety of strategies to continue its monitoring of industry-supported symposia to ensure that the information presented in these sessions was balanced and unbiased.

Since 1998 APA has used the Resident Monitor Program for both the annual meeting and the Institute on Psychiatric Ser-

please see ***Annual Meeting*** *on page 12*

Who Attends the Annual Meeting?



Source: 2002 APA Annual Meeting Evaluation Report.

Thompson

continued from facing page

stitution's 16 graduate medical education programs. Most of these are research oriented, although some are clinical. He indicated that research training has always been a personal interest. He is a health services researcher, with a number of publications on the severely mentally ill, minorities, and nosology. At the University of Maryland, he helped create a resident research track. At APA he led the Program for Minority Research Training in Psychiatry and worked with the Office of Research to enhance research training in psychiatry residencies.

About his new position, Thompson commented, "I'm looking forward to the opportunity to build the NIH research training operation into the finest operation of its kind in the world. I believe that NIH should be at the forefront of education, and I will work hard to make that the case."

Thompson is becoming an officer in the U.S. Public Health Service and retains his faculty appointment at the University of Maryland in Baltimore. ■

Annual Meeting

continued from page 11

vices, which is held in October each year (see page 25). Using guidelines developed by APA's Committee on Commercial Support, psychiatry residents monitor the following: balance in each presentation, disclosure of conflict of interest by faculty, use of generic/brand names, disclosure of any discussion of unapproved or investigated uses, and any bias toward the supporting company's products.

Presenters must follow the Accreditation Council for Continuing Medical Education and APA guidelines for commercial support, which include sanctions for noncompliance as approved by APA's Board of Trustees.

The report concluded that APA's symposia oversight measures were effective, since the majority of respondents agreed that "multiple viewpoints" and "an unbiased view of the topic" were presented in the sessions (94 percent). Ninety-eight percent agreed that the symposia met their educational objectives, and 96 percent of registrants also agreed that the ISS would help them improve the effectiveness of their practices.

The evaluation of the 2002 annual meeting was based on responses on the General Evaluation Form, which was included with registration materials, distributed on site, and mailed to registrants after the meeting. The evaluation survey could also be completed at nine computer terminals in the APA Resource Center and at kiosks in the Exhibit Hall.

Of the 5,529 respondents to the general evaluation survey, almost 90 percent identified themselves as psychiatrists. Nonphysician health professionals made up only a small portion (4 percent) of the evaluation respondents. Additional details on attendees appear in the chart on page 11.

As part of the evaluation, meeting participants were asked what topics they would like to learn more about at future annual meetings. The participants expressed interest in more sessions on psychotherapy of all types, child psychiatry, mental retardation, and substance abuse, for instance.

Registrants were also asked to comment on how the meeting and facilities could be improved in the future. Some said that the "official" accommodations were too expensive or that they had a difficult time booking their hotel reservations, while others believed that the bus service could have been improved somewhat.

Due to the large number of attendees that led to overflow crowds at some sessions, a number of registrants suggested that larger meeting spaces be provided.

The majority of the registrants, however, responded positively on the evaluation forms. "The meeting was very well planned and organized," wrote one respondent. "I enjoyed learning from all the great papers presented."

Another wrote, "The APA [meeting] is always fun and educational. You get to meet your long-lost colleagues and learn new things at the same time."

In addition, minority medical students who expressed interest in becoming psychiatrists and attended the meeting at the invitation of the APA/CMHS and APA/AstraZeneca fellowships were questioned about their reactions to the meeting. They too were impressed with what they experienced. One fourth-year student wrote, "Attending this meeting has definitely cemented my ambition to become a child psychiatrist. I even got a chance to meet and talk with [APA President] Dr. Richard Harding—a discussion I will never forget."

Another fourth-year student commented, "I thought the sessions on minority mental health needs and on networking among minority physicians, residents, and fellows were extremely helpful. . . . I began to see places where I could contribute via research and through service on one of the APA committees."

A third-year student said, "Having attended the annual meeting, I am one step closer to finalizing my career choice in psychiatry." ■

District Branch Executive Director Honored

Philip Workman, the executive director of the Ohio Psychiatric Association (right), was presented with NAMI Ohio's 2002 Mental Health Champion Award by its executive director, **Terry Russell,** in June.

Workman was cited for his "commitment to the citizens of Ohio suffering with mental illness." His selection was no surprise to his colleagues.

"He is well known and respected by many APA leaders, members, and staff," said Brien W. Dyer, M.D., president of the OPA, "and has been a mentor to other district branch executives. In fact, he was the first district branch executive to receive the APA Assembly Warren Williams Award. Here in Ohio, his advocacy work for both the patients we serve and for our profession is most noteworthy."

Terry Russell, executive director of NAMI Ohio, told *Psychiatric News*, "Phil is so deserving of this award. Phil Workman is a great friend to the consumer and family movement in Ohio. NAMI Ohio has always been able to count on Phil as an ally on issues that are important to advocates for the most severely mentally disabled. He is a true champion in the fight for access to services for Ohio's mental health consumers and their families."

Over the past 19 years, Workman has been extremely active within APA, said Dyer. Through his support and advocacy efforts with the OPA, he has contributed significantly to strengthening relationships between patients, families, and psychiatrists. One way he has done this is by creating a partnership between NAMI Ohio and OPA that has resulted in educational programs for each other's membership. In addition, he was one of the founding members of a statewide coalition formed in 1984 to seek parity coverage for mental illnesses, alcoholism, and drug addiction.

At APA, he has been a member of the Task Force on APA/DB Partnership, Work Group to Study Dues, and Task Force to Develop Procedures for Revenue Sharing. He is currently a member of the APA Information Systems Task Force.

In Memoriam

The following is a list of members whose deaths were reported to APA from March 1 through June 30.

Z. Alexander Aarons, M.D.
Amr A. Abdel Fattah, M.D.
David Abrahamsen, M.D.
H. Frederick Adickes Jr., M.D.
Juan Manuel Armero, M.D.
Robert E. Arnot, M.D.
Robert C. Ascher, M.D.
Teresita Y. Awa-Bajas, M.D.
A. John Bambara, M.D.
Anne Barone, M.D.
H. Craig Bell, M.D.
Deane W. Benton, M.D.
Mary Louise Blackmer, M.D.
Margaretta K. Bowers, M.D.
Edmund M. Braun, M.D.
Elizabeth Brodie, M.D.
Claude L. Brown, M.D.
Marthe E. Brown, M.D.
R. Wells Buddington, M.D.
Christopher Bull, M.D.
William H. Burba, M.D.
Mischa Caplan, M.D.
Daniel Cappon, M.D.
Michael Chaplik, M.D.
Lisa Chertkov, M.D.
Louise Stone Clark, M.D.
E. Winston Cochran, M.D.
Earl Cohen, M.D.
Mandel E. Cohen, M.D.
Harvey Joshua Dain, M.D.
Zira De Fries, M.D.
Jane Doller, M.D.
Rosemary Dykema, M.D.
Jarl E. Dyrud, M.D.
Paul G. Ecker, M.D.
Peter G. Edgell, M.D.
Louis C. English, M.D.
M. Richard Finn, M.D.
Thomas South Fox, M.D.
Mark Leslie Freeman, M.D.
Milton David Friedenberg, M.D.
Arnold J. Friedhoff, M.D.
Alexander J. Friedman, M.D.
Patrick B. Friel, M.D.
James M. Fries, M.D.
Frank Gelbman, M.D.
James P. Ginsberg, M.D.
Ralph A. Goddard, M.D.
Leonard Gold, M.D.
Simon Gold, M.D.
Narayan C. Gupta, M.D.
Albert Vale Harrison, M.D.
Jane M. Hatheway, M.D.
Philip Sidney Herbert Jr., M.D.
Malcolm Hill, M.D.
Laverne M. Howie, M.D.
Myron R. Hurwitz, M.D.
David E. Irigoyen, M.D.
Wallace Ironside, M.D.
Armand B. Kapik, M.D.
William E. Kelly, M.D.
James A. Kennedy, M.D.
Judith Helene King, M.D.
Charles H. Klaif, M.D.
John James Kluck Jr., M.D.
Peter Knowlton, M.D.
Jack Krauss, M.D.
Clarence J. Kurth, M.D.
Orthello R. Langworthy, M.D.
David Bruce Larson, M.D.
Robert L. Lewis, M.D.
Charles Elroy Llewellyn Jr., M.D.
James Loutzenhiser, M.D.
James V. Lowry, M.D.
Eugene Makarowsky, M.D.
Reuben Mark, M.D.
Katharine H. Martin, M.D.
Gerald C. McCarthy, M.D.
Helen B. McAllister, M.D.
Ann M. Minnema, M.D.
Arthur A. Mintz, M.D.
Stuart E. Nichols Jr., M.D.
John I. Nurnberger, M.D.
Dimitrios Padouvas, M.D.
Pete C. Palasota, M.D.
Mahmoud A. Parsa, M.D.
Alvin U. Perez-Aquino, M.D.
Thomas W. Phillips Jr., M.D.
Samuel H. Pomerantz, M.D.
Robert C. Prall, M.D.
Diana Kristine Quinn, M.D.
Robert Samuel Ravetz, D.O.
D. F. Rendinell, M.D.
George H. Reye, M.D.
Matilda Rice, M.D.
Herman Rickless, M.D.
Kenneth Rubin, M.D.
Theodosy Samotulka, M.D.
Louis P. Saxe, M.D.
Jacob Schut, M.D.
Chaim F. Shatan, M.D.
Earl D. Short Jr., M.D.
Donald J. Silberman, M.D.
Robert A. Simenson, M.D.
William S. Simpson, M.D.
Beatrice S. Sloan, M.D.
Arlene J. Smith, M.D.
Rudolph J. Sommer, M.D.
Milton Joseph Steinhardt, M.D.
Bernard S. Stell, M.D.
Edward M. Stempel, M.D.
Robert L. Stubblefield, M.D.
Thomas W. Sugars, M.D.
George H. Sweeney, M.D.
Edward R. Tallman, M.D.
Hugo Taussig, M.D.
Herman J. Teagno, M.D.
Joseph M. Tobin, M.D.
William L. Unger, M.D.
Albert Biagio Valicenti, M.D.
Charles A. Vieth, M.D.
Harold M. Visotsky, M.D.
Lawrence L. Washburn Jr., M.D.
Lance S. Wright, M.D.
Richard Jed Wyatt, M.D.
Raymond D. Zipp, M.D.
Paul A. Zwick, M.D.

Evidence-Based Psychiatry: Fad or Fundamental?

BY SUSAN PADRINO, M.D.

Evidence-based medicine is a tool used in medical decision making that became popular when I was in medical school. Now that I am in residency, it is a part of my everyday vocabulary.

While in medical school, I thought evidence-based medicine (EBM) was an evil plot by epidemiologists and mathematicians to force me to learn their arcane language: positive predictive value, number needed to treat, sensitivity, specificity, and on and on. Now that I am a resident, I feel more confident in my medical decisions when I can say "the data show this" or "the data show that." Even when I have to say "there are no data for this," I feel my decision is more valid. Sometimes I even use this statement with patients, particularly when they are trying to convince me to prescribe the latest drug they saw advertised on television.

There are numerous benefits to making decisions with the evidence in mind, but the limitations clearly deserve mention. Most obvious is that "data" are not always available. This especially applies to the complex, profound interaction between patient and psychiatrist, which is maybe one of psychiatry's most special aspects. The art of medicine is not easily quantified, and if you can't quantify something, it is difficult to study it.

Furthermore, not everything or everyone can be studied. This is not a complete truth, because in some ways the information we collect about our patients is very often used in one study or another, even if it is just a study by the insurance company to assess "quality."

The information age and technological advances that drive it are making data collection and sorting easier. However, assessing which information is useful and which is useless can be difficult. The endorsers of the information usually have more sophisticated number crunchers at their disposal than information readers. But that limitation can be countered by making readers more informed. This is happening in my residency training program and many others throughout the country.

Another challenge in incorporating EBM into psychiatry is that the usual sources of funding for studies favor drugs over nonpharmacologic therapies. Most double-blind, placebo-controlled trials (which provide the "highest" level of data and are very expensive) involve assessment of medication benefits and pharmaceutical company funding.

So why use EBM in psychiatry? There are numerous advantages to incorporating evidence-based decisions into training and practice. Some people (maybe even me) have criticized the idea as supporting "cookbook" medicine. The concern is that once guidelines for treatment are established, medical decision making will be unnecessary—simply follow the prescribed treatment and move to the next patient. In practice, guidelines can provide only the basic strategy, and the details of the treatment plan depend on patient and physician.

How to incorporate evidence-based decisions into the details is the next question. Search technology and EBM databases are quite advanced and can often yield several references for a question as specific as "How long do I continue lithium when used as an adjunct treatment for unipolar depression?" In years past, a resident might ask this question of an attending or two, and maybe a colleague, and would likely get several different answers, mostly based on personal preference or a few anecdotes. Now residents have the power to search across thousands of references to find whether anyone else was curious enough about the same question to perform a study. And EBM training allows us to understand some of the cryptic language used in the fine print so that we can judge whether the study is worth believing.

Another reason to include psychiatry in EBM relates to the first limitation I discussed above. I believe there are ways to measure the effects of the interaction between patient and psychiatrist. Some believe that this relationship is the main force behind the placebo effect. Researchers in nonpsychiatric fields acknowledge the importance of the patient-physician interaction, because trials are designed to keep this constant among study groups. And more powerful than the effect of generic interaction is the effect of trained and thoughtful interaction, or therapy. What if we had "data" to support therapy? In fact, there are some data to support certain types of therapy for certain diagnoses. But what if we had a lot more? Then we could turn to managed care organizations with more ammunition to justify treatment decisions. And why accept less rigorous information about therapy than we accept about new (or old) medications? Research suggests that the brain is altered by therapy, much as it is with pharmacology. Our standards should be high.

Residents are in a good position to question old practices and to use clinical curiosity in a way that can benefit the field of psychiatry. Residents need to learn how data are collected and presented, how they can be manipulated, when they are useful, and when they are useless. If we don't learn, we may be more easily manipulated by pharmaceutical companies, by patients, or by the media. It is our responsibility to be informed, and EBM provides the tools.

Please contact me about this and other issues at susanpadrino_mitte@hotmail.com. ■

Dr. Padrino is APA's member-in-training trustee.

Breaking the Silence May Be Best Medicine to Prevent Suicide

Safely back from the brink of suicide, Ross Szabo talks to young audiences nationwide about seeking help for symptoms of depression.

BY EVE BENDER

The stigma that keeps parents and teens from discussing the very real symptoms of adolescent depression carries with it deadly consequences. According to the National Mental Health Awareness Campaign (NMHAC), approximately 20 percent of high school students have seriously considered or attempted suicide. Furthermore, suicide is the third-leading cause of death for people aged 15 to 24.

In an urgent effort to reduce suicide prevalence in young people and educate the public about the signs and symptoms of depression, the NMHAC launched its "Signs for Life" campaign in May.

As part of the campaign, the NMHAC has developed two tools to help prevent suicide. One is a wallet-sized card for young people containing a list of depression signs and a toll-free phone number they can call to receive counseling and information. The other is a brochure for adolescents and adults about depression and suicide in teens.

Harold Koplewicz, M.D., founder and director of the New York University Child Study Center, and Ross Szabo, director of youth outreach for NMHAC, have been promoting these tools while facilitating a national dialogue on the warning signs of depression and suicide in teens. In a media tour to kick off the Signs for Life campaign, the duo has appeared on a number of local morning news shows across the country to discuss the topic from different perspectives.

Szabo, 24, acknowledges surviving depression and a suicide attempt. He has found that by telling his story about living with bipolar disorder, he has been able to reach thousands of young people and encourage them to open up about their own experiences with mental illness.

"Many young people feel isolated and lonely because they are suffering from a mental illness like depression, or may have thoughts of suicide and don't think there is anyone else like them," Szabo told *Psychiatric News*.

In the fall of his senior year of high school, Szabo was stricken with a bout of depression that kept worsening. "I started feeling quite lonely, which was odd, since I had a number of friends and was involved in a number of school activities." Despite these feelings, Szabo said he'd usually "put a happy face on" and not say a word to anyone about what he was feeling. Whenever he was alone each day, however, he'd cry.

By January, the feelings of loneliness and desperation reached a crescendo, and Szabo decided that he would take his life in the bathroom of his house. However, in the nick of time, his father walked by and, noting that his son was upset, asked him to come downstairs. That's when Szabo told his parents he had planned to kill himself.

Later that year, a psychologist spoke to Szabo's graduating class about mental illness. When he described the symptoms of mental illness, Szabo's classmates began to laugh. "I became very angry," he recalled. When a teacher called Szabo out into the hall to ask him what was wrong, he replied, "I have a mental illness, and I don't appreciate people laughing." His teacher said that his classmates were laughing because they didn't understand mental illness and asked Szabo what he was going to do about it.

So began Szabo's career as a spokesperson and advocate. He soon spoke to his classmates about his experiences with mental illness. Although many of them were taken aback to learn that he had a mental illness, others "came forward and said that they knew someone with a mental illness, or they had experiences similar to mine."

The crushing lows and manic highs of bipolar disorder also followed him throughout his college years at American University in Washington, D.C., but with treatment and family support, he graduated in May.

"It is important to take away the stigma of mental illness and encourage young people to express their feelings and seek help before they get to the breaking point," he said.

Many youth do reach their breaking points, where they feel as if there is no other option available to them but suicide—5,000 people between the ages of 15 and 24 commit suicide each year, Koplewicz pointed out.

Koplewicz complements Szabo's perspective on mental illness with his clinical expertise. In addition to his post at the child center, he is vice chair of the department of psychiatry and a professor of clinical psychiatry and pediatrics at New York University.

"Many parents believe that adolescence is a time of angst, moodiness, and rebellion," he told *Psychiatric News*. "Therefore, when a teenager's mood changes, most parents think that change is a normal part of development."

Koplewicz noted that "many parents aren't ready to ask their teens the important questions about what could be symptoms of depression, or feel their children wouldn't be receptive to that discussion."

Parents aren't the only ones likely to minimize symptoms of depression, however. "Most teens do not want to take medications for depression or to admit that they have very real medical illness," he observed.

Koplewicz is the author of several books on adolescent depression. His latest book, *More Than Moody: Recognizing and Treating Adolescent Depression*, is scheduled to be published by Penguin Putnam Inc. in October.

Information on the Signs for Life campaign, including free wallet-sized cards and brochures on teen depression and suicide, are available by calling (877) 495-0009 or logging on to the National Mental Health Awareness Campaign Web site at <www.nostigma.org>. ■

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Gene Variant Points To Frightening Discovery

NIMH researchers have linked inheritance of a particular variation of the serotonin reuptake transporter to a biased view of frightening visual images.

BY JIM ROSACK

A team of National Institute of Mental Health (NIMH) researchers has linked the inheritance of a specific gene to a difference in how people respond to pictures of scary faces, adding that people with the gene could be at higher risk for anxiety disorders.

The researchers used functional magnetic resonance imaging (fMRI) to measure how active a particular area of each subject's brain became in response to visual images of fearful or angry faces.

"How biologically reactive we are to a signal of danger, which is partly heritable," explained Daniel Weinberger, M.D., chief of NIMH's Clinical Brain Disorders Branch, "can place us at risk for an anxiety disorder or it may be an adaptive, positive attribute, such as increased vigilance, depending on the circumstances."

Weinberger, the lead investigator and principal author of the report, emphasized in an NIMH press release, however, that anxiety is a complex experience that is not caused by one gene or any specific environmental factor but rather a complex interaction of many genes and environmental factors. The report, which appeared in the July 19 issue of *Science*, shows how a "variation in a gene exerts its influence on the brain's center for fear processing," he said.

The gene identified by the group codes for the protein in neuronal cell membranes responsible for the recycling of serotonin from synapses—the serotonin reuptake transporter. (Selective serotonin reuptake inhibitor drugs, used as antidepressants, are believed to somehow block this transporter.) The two most common variations of the gene occur in a region of the gene that acts like a "dimmer switch," according to the NIMH group, controlling the level of the gene's turning on and off. The "short variant" of the gene makes less protein, resulting in fewer transporters. Therefore, higher levels of serotonin remain in the synapse. As such, there is more binding of the neurotransmitter to serotonin receptors on connecting neurons resulting in a higher degree of stimulation of the connecting neuron. This difference in the "level of activation" can be seen in fMRI images taken at different times, under different circumstances.

The researchers used fMRI to look at 28 subjects while completing a facial emotion-matching task on a computer screen. Subjects were asked to look at a picture of two faces, each expressing either anger or fear, and match the correct picture to a third face, established as being angry or afraid.

The facial emotion-matching task is known to activate the amygdala, the brain structure that the NIMH researchers referred to as the "hub of fear." Imaging monitored the activity of the amygdala in each subject during the task. Weinberger said that those subjects with one or two copies of the short gene variation showed greater activation of their amygdala on the right side of the brain, which specializes in facial recognition. When the same subjects were asked to perform a common cognitive test that does not involve emotion, no effects of the gene difference were seen.

The current study was not capable of determining any differences in anxiety level or traits related to the serotonin transporter gene variations as that was not the primary goal, and the team believes its sample was too small to see any significant correlation if they had looked for it. Earlier studies, however, in particular by Dennis Murphy, M.D., also at NIMH, have found that the variants accounted for 3 percent to 4 percent of the variance they found in anxiety traits.

"This fMRI study takes the genetic analysis forward from the level of neurobiology, closing one more link in the chain of causality between a functional difference in a gene and a complex behavior," noted David Goldman, M.D., a researcher at the National Institute on Alcohol Abuse and Alcoholism and coauthor of the report.

Weinberger agreed, noting that "this finding may lend credence to earlier reports linking the short variant to slightly higher levels of anxiety. It provides potential insight into one factor that contributes to the way people experience emotion."

An abstract of "Serotonin Transporter Genetic Variation and the Response of the Human Amygdala" is posted on the Web at <www.sciencemag.org/cgi/content/abstract/297/5580/400?>. ■

Data Suggest It's Time To Rethink the Cerebellum

Patients with cerebellar diseases may experience not just deterioration in physical movements, but also psychiatric disorders. Thus, patients with cerebellar diseases may need psychiatric as well as neurological help.

BY JOAN AREHART-TREICHEL

Back in the 1990s, Patricia Hamilton, a financial analyst with IBM, decided to give up her job because she had spinocerebellar ataxia, an autosomal dominant disorder of the cerebellum that she had inherited from her father and her grandfather.

"Increasing difficulty with balance in walking, problems with slurred speech, and trouble focusing made it clear to me that I had to stop working there," Hamilton wrote on her Internet homepage.

Usually patients like Hamilton are not on the radar screen of psychiatrists. But maybe they should be, a new study conducted by Johns Hopkins University scientists and published in the August *American Journal of Psychiatry* suggests. The study has found that a number of persons with diseases like Hamilton's also have psychiatric disorders.

True, the cerebellum has long been known to be concerned with muscle tone, balance, conversion of muscle contractions into smooth, coordinated movements, and other physical movement matters. And diseases of the cerebellum have long been known to lead to deterioration in physical movements. But during the past decade or so, evidence has started cropping up that the cerebellum may influence cognition and emotions as well. What's more, some case reports have suggested that degenerative cerebellar diseases can trigger psychological disturbances.

Russell Margolis, M.D., an associate professor of psychiatry at Johns Hopkins University School of Medicine, and both psychiatric and neurological colleagues at that institution, decided to conduct a study to determine whether the latter is truly the case, and if so, what types of psychological disturbances such patients might have.

Margolis and his colleagues recruited 81 persons to participate in their study. Thirty-one had degenerative cerebellar diseases—spinocerebellar ataxia or multisystem atrophy—for five years or more. Twenty-one had Huntington's disease, a disease that impairs physical movement, but that arises from damage to the basal ganglia of the brain, not to the cerebellum. These subjects had had Huntington's for about the same length of time that the cerebellar subjects had had their diseases and thus served as a disease-comparison group. Twenty-nine individuals who were neurologically normal served as a control group. Subjects in all three groups were similar in age, sex, race, and educational level.

Each subject underwent a comprehensive psychiatric assessment by a neuropsychiatrist experienced in the assessment and treatment of patients with movement disorders. An "informant" for each subject supplied more information. Informants were specifically asked about distinct, enduring changes in personality since the onset of the movement disorder or, for the healthy control group, over recent years. To avoid the assumption of a causal relationship between personality change and cognitive impairment, the diagnosis of the former was made independently from that of the latter. The data on each subject were then reviewed by a second neuropsychiatrist who was unaware of the neurological diagnosis, and a consensus psychiatric diagnosis (or diagnoses) for the subjects was established. The investigators then compared findings among the groups.

First, there was a highly statistically significant difference in the prevalence of noncognitive psychiatric disorders between the degenerative cerebellar disease group and the healthy control group, which did not surprise the researchers. Specifically, the overall rate of noncognitive psychiatric disorders in the cerebellar group was 77 percent (24 of 31 subjects) versus 41 percent (12 of 29 subjects) in the control group. Sixty-eight percent of the cerebellar group (21 of 31 subjects) had mood disorders, whereas only 32 percent of the healthy control group did (nine of 29). Twenty-six percent of the cerebellar group had experienced a personality change, whereas none in the healthy control group had.

Second, the prevalence of noncognitive psychiatric disorders in the cerebellar group—77 percent—was nearly the same as that in the Huntington's group, which was 81 percent. This finding surprised the researchers. They did not expect the cerebellar group to have nearly as many psychiatric problems as the Huntington's group, since Huntington's is such a devastating neurological disease.

Granted, the Huntington's group had a much higher prevalence of cognitive impairment than the cerebellar group did—71 percent versus 19 percent—but the 19 percent is still noteworthy, the investigators believe.

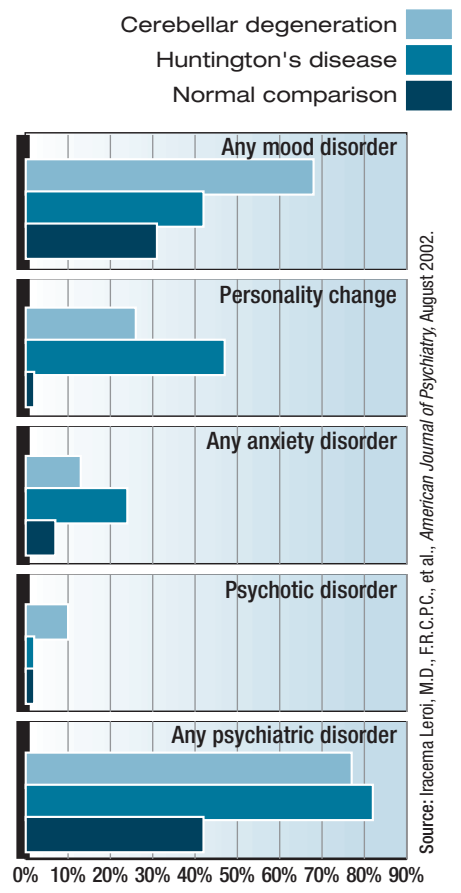
Thus, the high rates of psychiatric disorders and the fairly high rate of cognitive impairment found in the degenerative cerebellar disease subjects suggest that many, if not most, persons with such diseases would profit from psychiatric help, Margolis and his team concluded in their study report.

"Although the underlying neurodegeneration in degenerative cerebellar diseases may not yet be treatable," they explained, "management of the accompanying psychiatric disorders and cognitive impairment with a combination of education, pharmacotherapy, and supportive psychotherapy may have a major impact on quality of life for patients and their families."

Unfortunately, most persons who could use such help are probably not getting it because of American psychiatry and American neurology having been split into discrete medical specialties, Stuart Yudofsky, M.D., and Robert Hales, M.D., observed in an accompanying editorial. Yudofsky is chair of psychiatry at Baylor University and editor of the *Journal of Neuropsychiatry and Clinical Neurosciences*. Hales is chair of psychiatry at the University of California, Davis, associate editor of the journal, and editor-in-chief of American Psychiatric Publishing Inc.'s book division.

The study was funded by the National Alliance for Research on Schizophrenia and Affective Disorders and by the National Institutes of Health.

The study report, "Psychopathology in Patients With Degenerative Cerebellar Diseases: A Comparison to Huntington's Disease," is posted on the journal's Web site at <http://ajp.psychiatryonline.org/cgi/content/full/159/8/1306?>. ■



Researchers were surprised to find that the prevalence of noncognitive psychiatric disorders in the cerebellar-degeneration group was nearly the same as in the Huntington's-disease group.

Isolating Isomers Enhances Antidepressant Efficacy, Study Shows

Data evaluating escitalopram, the new single-isomer version of the antidepressant citalopram, indicate that it may be a significant improvement over the original.

BY JIM ROSACK

Two research reports presented at the 23rd Collegium Internationale NeuroPsychopharmacologium Congress in Montreal in June indicate that isolation of active, single forms of molecules, called isomers, from mixed-isomer compounds can yield significant improvements in efficacy and in safety and tolerability profiles.

The first report, about the antidepressant escitalopram (Lexapro), which was developed in Europe by Lundbeck and licensed to Forest Laboratories for marketing in the United States, indicates that the drug is more than twice as potent at increasing brain serotonin availability as its parent compound, citalopram (Celexa). Escitalopram is the S-isomer of citalopram, which is a compound that contains two isomers—or mirror-image forms (labeled the S and R isomers)—of the same molecule.

Pharmacologists are finding that more often than not, one of the two isomers in mixed compounds is much more "active" than the other isomer, and is often responsible for therapeutic action of the compound, while the second isomer is often associated with secondary drug effects, which could manifest as side effects.

The second research report indicates that when escitalopram (the compound's generic name, simply indicating the chemical name, S-citalopram, phonetically) is administered along with the R-isomer, the ability of the S-isomer to increase serotonin levels actually declines, indicating that the R-isomer may be interfering with the active S-isomer's ability to increase serotonin availability in the brain, according to Jack Gorman, M.D., the Lieber Professor and vice chair for research at the College of Physicians and Surgeons of Columbia University, who was involved in the studies.

The mechanism by which the R-isomer affects the ability of the S-isomer to boost serotonin levels is still a mystery. However, pharmacologists at Lundbeck and Forest suspect that the two isomers are competing to bind with serotonin reuptake transporters. While the S-isomer is very potent at binding to and blocking the reuptake transporter, the R-isomer binds but may not as effectively disable reuptake.

Overall, clinical trial data for escitalopram have been quite favorable, showing increased potency compared with citalopram. Previous studies have indicated that the new drug also has a reduced drug-interaction profile and is well tolerated, with few significant or serious side effects.

A new drug application for escitalopram was submitted to the FDA in March 2001, and the agency issued an "approvable" letter for the new drug last January. A Forest spokesperson told *Psychiatric News* that final approval for marketing is expected within the "very near future." ■

Several Factors Mitigate Seniors' High Suicide Risk

Just as depression, poor sleep, and limited social support may put seniors at greater risk of suicide, ample social support and religious belief may cushion them from it.

BY JOAN AREHART-TREICHEL

Older Americans, and especially older white men, are at greater risk of suicide than any other group. And now some of the factors that increase seniors' suicide risk have been identified in two studies reported in the August *American Journal of Geriatric Psychiatry*.

Those factors are depression, poor sleep quality, limited social support, and the possession of firearms.

In the first study, Carolyn Turvey, Ph.D., of the University of Iowa College of Medicine, and her colleagues followed some 15,000 elderly subjects' mental and physical health over a decade as part of the Established Populations for Epidemiological Studies of the Elderly.

Of those subjects, 21 committed suicide during the study period. Baseline and follow-up data about these 21 subjects were then compared with baseline and follow-up data about the remaining subjects (controls) to identify suicide risk factors.

Depression, poor sleep quality, and absence of a relative or friend to confide in turned out to be risk factors, whereas medical illness and alcohol use were not.

Interestingly, depression, poor sleep quality, and limited social support have previously been identified as risk factors for death by natural causes, as well as for death by suicide. Or as Turvey and her team noted in their study report: "It appears that these variables erode a will to live that affects mortality even in the absence of suicidal tendencies."

In the second study, Yeates Conwell, M.D., of the University of Rochester School of Medicine, and his colleagues probed the role of firearms in senior suicide risk, since firearms are the most common method of suicide used by both men and women in later life.

The subjects included 86 persons aged 50 or older who had committed suicide and 86 community control subjects individually matched on age, sex, race, and county of residence.

The presence of a firearm in the home was found to be associated with an increased risk of suicide, even after controlling for psychiatric illness. Elevated risk was accounted for by access to handguns rather than to long guns and was more pronounced in men than in women.

However, it is probably not the presence of a firearm in the home per se that constitutes a risk factor for senior suicides, but rather the recent purchase of a firearm, Conwell and his team contended. The reason, they explained in their study report, is that firearm suicide rates for the elderly have declined markedly in states that have instituted waiting periods or background checks, or both, for handgun purchases.

Yet just as depression, poor sleep quality, limited social support, and the recent purchase of a handgun may put seniors at risk of suicide, social support and religious beliefs may help protect them against it. The reason to believe that this is the case comes from a third study published in the August *American Journal of Geriatric Psychiatry*.

This study, headed by Joan Cook, Ph.D., of the University of Pennsylvania, focused on a senior group with a very low suicide risk—older African-American women. Indeed, compared with older white men, older African-American men, and older white women, senior African-American women have had the lowest suicide rate for decades.

Cook and her colleagues interviewed 835 elderly African Americans, 77 percent of whom were women, in urban public housing developments to find out how many were having suicidal thoughts. They found that only 27 (about 3 percent) were. They then compared characteristics of the suicide-contemplation subjects with the subjects not contemplating suicide and found that the former were more likely to be experiencing depression and anxiety and to have less life satisfaction, fewer social supports, and fewer religious beliefs. In fact, some 90 percent of control subjects reported that they obtained a great deal of support and comfort from religion.

The study reports "Risk Factors for Late-Life Suicide: A Prospective, Community-Based Study," "Access to Firearms and Risk for Suicide in Middle-Aged and Older Adults," and "Suicidality in Older Americans: Findings From the EPOCH Study" are posted on the Web at <http://ajgp.psychiatryonline.org> under the August issue. ■

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Experts Study Consequences Of Sleep Deprivation

The effects of sleep loss and advances in narcolepsy were two of the topics discussed at the annual meeting of Associated Professional Sleep Societies.

BY LYNNE LAMBERG

Too little sleep and excessive sleepiness in waking hours hobble the lives of an estimated 70 million Americans. Highlights of the annual meeting of the Associated Professional Sleep Societies (APSS) in Seattle in June included talks on progress in assessing the impact of sleep loss and in understanding the cause of narcolepsy by leading researchers in these fields.

The meeting, a joint effort of the Sleep Research Society (SRS) and the American Academy of Sleep Medicine (AASM), drew 3,300 registrants.

In sleepy people, attention wanders and response time slows. Cognitive functioning varies more from moment to moment than it does when people are well rested. Measuring "wake state instability" shows how sleep loss impairs cognitive performance, David Dinges, Ph.D., said in the APSS meeting's opening address.

Society's love of caffeine belies its sleepiness, said Dinges, immediate past president of the SRS. He is a professor of psychology in psychiatry and director of the Unit for Experimental Psychiatry at the University of Pennsylvania School of Medicine. American adults drink an average of 3.2 cups of coffee a day, he reported. Coffee is second only to oil as the world's most widely traded commodity.

Dinges's laboratory focuses on quantifying the impact of chronic sleep restriction on cognitive and physiological functions and on developing measures to minimize performance decrements caused by sleep loss. Such studies benefit military troops, physicians on call, police, firefighters, transportation industry workers, and others providing round-the-clock services, as well as the population at large.

The researchers have studied 217 subjects in 17 studies, looking at people when they are well rested and after various amounts of sleep deprivation, up to 88 hours in some instances, mimicking military and emergency operations.

Subjects sit at a computer for 10 minutes every two hours around the clock, and perform the psychomotor vigilance task (PVT), a measure of sustained attention. They must press a button as fast as they can when a light goes on or a tone sounds. While individuals vary in ability, PVT performance follows a predictable pattern, with waves of alertness and sleepiness over the day in synchrony with daily biological rhythms.

After eight hours' sleep, subjects' reactions typically are quick and regular. Sleep loss increases the propensity for microsleeps, or brief involuntary behavioral lapses, Dinges said. These lead both to errors of omission (akin to failing to stop at a red light) and to errors of commission (swerving off the road). The more lapses people have, the longer and more irregular the lapses get.

After one night without sleep, PVT performance becomes unstable. After three nights without sleep, about 14 percent of subjects experience lapses that last as long as 30 seconds. "A four-second lapse at 60 miles per hour can kill you," Dinges said. Lapses peak at roughly 7 a.m. to 8 a.m., the same time that driving crashes caused by drowsiness most often occur.

People appear to pay a cognitive price for every minute of sleep below the amount they need to be optimally alert, Dinges said. Some people resist sleepiness better than others, however. Research in progress in Dinges's lab aims to resolve a long-standing question: whether an individual's response to sleep deprivation is a stable trait or can be altered by motivation. Pilot studies suggest the former.

Entrepreneurs now market nearly 90 gadgets they claim measure sleepiness in real-world settings such as the cab of a truck or train, Dinges said. These devices assess waking brain-wave activity, eye blinks, eye movements, eyelid droops/closures, pupillary responses, saccadic eye movements, heart-rate responses, electrodermal responses, and more. The debate continues about what action to take when such devices detect sleepiness in a driver.

In another invited lecture, Jerome Siegel, Ph.D., described recent findings on the role of the brain peptide hypocretin in narcolepsy, a disorder characterized by profound sleepiness. More than half of people with narcolepsy also suffer attacks of cataplexy, a sudden loss of muscle tone, often triggered by surprise, fear, or other strong emotions. Siegel is a professor of psychiatry and biobehavioral sciences at the University of California at Los Angeles and chief of neurobiology research at the Veterans Affairs Medical Center in Sepulveda, Calif.

Hypocretin is thought to play a key role in promoting wakefulness and in coordinating arousal and motor activity, Siegel said. Studies in his lab show hypocretin release is maximal in waking and in rapid eye movement (REM) sleep, and minimal in non-REM sleep.

In 1998 Siegel and Emmanuel Mignot, M.D., Ph.D., of Stanford University independently found that brains of people with narcolepsy contained 85 percent to 90 percent fewer hypocretin neurons than normal, as well as gliosis, or neural scarring, in the hypothalamus, where hypocretin cells reside. Selective destruction of hypocretin cells occurs in people with narcolepsy, Siegel said. This finding suggests that an autoimmune attack triggers the disorder.

Studies in Siegel's lab show that giving immunosuppressive and anti-inflammatory drugs by mouth to genetically narcoleptic dogs can delay the onset of narcolepsy and prevent the development of severe symptoms in these animals. This is the first treatment shown to affect development of narcolepsy symptoms in animals or humans.

Modafinil and other stimulants may reverse some symptoms of narcolepsy by activating surviving hypocretin cells, Siegel said. Administration of a hypocretin-based medication that could reverse the deficiency probably would prove a more effective treatment. Research under way aims to develop this type of drug.

In July the U.S. Food and Drug Administration approved the first medication specifically indicated for the treatment of cataplexy, Xyrem, manufactured by Orphan Medical. Xyrem's active ingredient is sodium oxybate, commonly known as gamma hydroxybutyrate, or GHB. The drug, which depresses breathing, can induce loss of consciousness. GHB's misuse for "date rape" led to its being taken off the market in the 1990s. Xyrem, said to cut cataplexy attacks by up to 70 percent, will be available to prescribers only through a single centralized pharmacy at (877) 67-XYREM. Patients must enroll in an FDA-monitored registry and must sign for the drug on delivery. The drug does not reduce sleepiness.

Next year's APSS meeting will celebrate the 50th anniversary of the discovery of REM sleep at the University of Chicago. It will be held in Chicago, June 3 to 8, 2003. More information is posted on the Web at <www.apss.org>. ■

NIH Sleep Research Plan Under Development

Attendees of the annual meeting of the Associated Professional Sleep Societies had the opportunity to review a draft of the National Sleep Disorders Research Plan, which will set priorities for the National Center on Sleep Disorders Research (NCSDR), housed at the National Institutes of Health. This draft is the first revision of a plan that has guided research since 1996. After surveying recent advances, it identifies gaps in the knowledge of basic sleep science and methodology, understanding of sleep and health, effects of restricted sleep, and the impact of sleep disorders.

Virtually all psychiatric disorders are associated with sleep disruption, the NCSDR plan notes. They are the most common cause of chronic insomnia. Moreover, insomnia also is a risk factor for the subsequent development of psychiatric disorders, including mood, anxiety, and substance use disorders. The plan lists as a top research priority the determination of whether insomnia and hypersomnia are modifiable risk factors for poor outcomes in the longitudinal course of psychiatric illnesses.

The draft plan is posted on the Web at <www.nhlbisupport.com/sleep/research/comments.pdf>.

Medicaid

continued from page 1

reduction in FMAP for federal Fiscal 2002.

The governors also proposed an increase in the rebates that states receive from pharmaceutical companies that participate in the Medicaid program by changing the pricing mechanism for determining the size of the mandated rebate.

According to NGA, U.S. Sens. Ben Nelson (D-Neb.) and Susan Collins (R-Maine) have agreed to support the NGA fiscal relief strategy and have introduced legislation that would provide a combination of a temporary increase in the Medicaid FMAP, a temporary and flexible block grant, and a hold-harmless provision so that states would not see their FMAPs reduced. At press time S 2570 had 14 cosponsors.

The bill would give the states $8.9 billion over the next 18 months.

According to the July 14 *Washington Post*, the Bush administration does not support the legislation.

Jay Cutler, J.D., director of APA's Division of Government Relations, told *Psychiatric News*, "APA is very concerned about the strains facing most state Medicaid budgets. We have received reports from states, such as Maryland and Virginia, that such basic treatment needs as physician visits and medications are jeopardized by budget shortfalls. We fully support an increase in the FMAP."

APA President Paul Appelbaum told *Psychiatric News*, "With states increasingly looking to Medicaid to fund care for people with serious mental illness, cuts in Medicaid funding are more threatening than ever to the well-being of the people we treat. Moreover, the same budget crunch that's affecting Medicaid is leading states to reduce services provided directly by their departments of mental health. Unless Congress provides support, as by increasing the FMAP, this one-two punch could be devastating to many people with mental illness."

More information about the NGA's annual meeting is posted on the NGA Web site at <www.nga.org/nga/legislativeUpdate/1,1169,C_ISSUE_BRIEF^D_4092,00.html>. ■

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APA 'Sows Research Seeds' For Next *DSM* Edition

It is hoped that a publication on *DSM* being released this month will stimulate investigators to conduct research useful to the development of *DSM-V.*

BY JOAN AREHART-TREICHEL

Is APA's *Diagnostic and Statistical Manual of Mental Disorders* world renowned? Absolutely. But could this famous nosology also be improved? Of course. And it is with an eye to making such improvement that APA is publishing a 300-page monograph this month titled *A Research Agenda for DSM-V.*

The editors of the monograph are David Kupfer, M.D., chair of psychiatry at the University of Pittsburgh; Michael First, M.D., a research psychiatrist at the New York State Psychiatric Institute; and Darrel Regier, M.D., executive director of the American Psychiatric Institute for Research and Education and director of APA's Division of Research.

The agenda actually had its inception in 1999. APA Medical Director Steven Mirin, M.D.; Steven Hyman, M.D., then director of the National Institute of Mental Health; and Kupfer, chair of APA's Committee on Psychiatric Diagnosis and Assessment, decided that it would be a good idea to bring researchers in neurobiology, genetics, and some other areas together to brainstorm how to ensure *DSM-V* might be placed on a firmer scientific footing than *DSM-IV.*

As First told *Psychiatric News*, "The idea was to cultivate research in advance of the *DSM-V* process to sow research seeds for *DSM-V.*"

The investigators whom Mirin, Hyman, and Kupfer decided to invite were, for the most part, not researchers who had been involved in previous *DSM* editions. "And part of the rationale for that," First explained, "was that they wanted people who were not constrained, not too closely involved with the original process, who were thinking out of the box."

In fall 1999 APA and NIMH cosponsored a research planning conference. As an outgrowth of this conference, work groups of investigators were formed to concentrate on areas deemed critical to improving *DSM.* In July 2000 Hyman and Kupfer met with Regier, who had recently joined APA, as well as with the heads of the work groups. Then in October 2000, the work group heads met with other work group members to further refine their strategies to set a research agenda *(Psychiatric News*, November 30, 2000). Now, almost two years later, the work groups have finished their work, and their recommendations are being published as the monograph *A Research Agenda for DSM-V.*

The monograph contains recommendations in the six different areas that the six work groups addressed: basic nomenclature issues, neuroscience and genetics, developmental diagnosis, gaps in the current diagnostic system, mental disorders and disability, and cross-cultural issues.

On page 113, for instance, the monograph states: "In one set of studies, potent risk factors for later psychiatric disorders have been identified among children whose symptoms do not meet current criteria for any categorical *DSM-IV* diagnoses. A few controlled prevention studies have begun to target such risk factors, but as knowledge of risk factors and their amenability to intervention increase, controlled prevention trials should also increase."

On page 157, the monograph asserts: "It is important to investigate whether there is a core group of *DSM* personality disorders that are seen as pathological or dysfunctional in diverse ethnic groups. Furthermore, it should be determined whether there are personality disorders that exist in certain ethnic groups and cultures that are not contained in standard *DSM* nosology."

And on page 215, the monograph declares: "As the field of psychiatric nosology moves forward in the era of genomics and more precise neuroscience, considerable opportunities exist to develop a much better understanding of the etiology and course of disability. This will best be accomplished by uncoupling disability and diagnosis. Disabilities warrant interventions that may differ from those needed for the relief of disease symptoms. Uncoupling the two concepts will facilitate research on the development of treatment for disabilities."

"The major thrust of the monograph," Kupfer told *Psychiatric News*, "is to highlight the need to search for new approaches to understanding pathophysiologic mechanisms that can both improve the validity of our diagnoses and increase the effectiveness of our treatment interventions. Rather than one specific recommendation, the major expectation was that these six work groups involving a number of interdisciplinary investigators and clinicians would develop chapters to encourage a research and analytic agenda that would integrate studies from basic/clinical neuroscience and behavior, epidemiology, clinical research, cross-cultural approaches, as well as approaches derived from clinical services."

As Regier explained it: "The intent of this monograph is to stimulate additional research that will improve the validity of the criteria for psychiatric diagnoses. By that I mean criteria that will better describe the etiology or causes of disorders, the location in the brain where specific

please see ***Next* DSM** *on facing page*

APA Statement on RAD Warns Against Dangerous Treatments

Caution is the watchword for parents seeking evaluation and treatment for children with a rare psychiatric disorder that hinders a child's ability to connect with adults.

BY EVE BENDER

Reactive attachment disorder (RAD) is a psychiatric condition affecting a small number of children and is widely misunderstood by the general public. In addition, unproven treatment strategies used in children who are suspected to have the disorder can be harmful and even fatal, according to an APA position statement released in July.

In response to a number of requests from psychiatrists to develop a policy on the disorder and provide the public with the most accurate information available, members of the APA Council on Children, Adolescents, and Their Families (now the Council on Child and Adolescent Psychiatry) worked in conjunction with the Committee on Preschool Children to craft the statement.

Term Misused

RAD is a complex disorder characterized by a child's inability to form normal attachments to others, according to the statement, and a parent or physician may first notice problems in attachment to the caregiver in the latter part of the child's first year.

"I think there is a lot of confusion in the public about the diagnosis of RAD, and the term is frequently misused," said David Fassler, M.D., an APA trustee-at-large and former chair of the Council on Children, Adolescents, and Their Families.

Fassler, who led the effort to create the position statement, added that council members "were also concerned over reports about the use of scientifically unproven and potentially dangerous approaches to treating what has been referred to as RAD."

The position statement warns both clinicians and caretakers of the dangers associated with so-called coercive holding therapies and "rebirthing" techniques that have sometimes been used to treat children with RAD.

In one recent case, such treatment proved fatal when uncredentialed therapists in a Colorado counseling center bound a 10-year-old girl in a sheet and sat on pillows placed around her head in an effort to simulate labor contractions. The goal? To let the girl be "reborn" into a world where past traumas would no longer exist for her. The girl died at a Denver hospital the day after the procedure.

Children with RAD may appear to be detached, unresponsive, inhibited, or reluctant to engage in age-appropriate social interactions. However, some children with RAD can be overly and inappropriately social, even with strangers. These problems may persist as the child grows older.

> **"I think there is a lot of confusion in the public about the diagnosis of RAD, and the term is frequently misused."**

Many children with RAD have been physically, emotionally, or sexually abused, according to the policy statement, while others may have experienced long periods of isolation or neglect. In addition, some of these children have had "multiple or traumatic losses or changes in their primary caregiver."

Although there are no prevalence estimates available for the disorder, Fassler stressed that it is relatively rare and that not all children who have endured traumatic circumstances in early life will develop RAD. "The child's temperament figures in his or her ability to cope with various stressful early life experiences," he said.

Advice to Parents, Caregivers

The statement advises parents or caregivers of children who show symptoms of RAD to do the following:

- Seek a comprehensive evaluation by an appropriately trained, qualified, and experienced mental health professional prior to the initiation of any treatment plan.
- Ask questions about the results of the evaluation.
- Be clear about the potential risks and benefits of any intervention.
- Feel free to seek a second opinion if questions or concerns remain.

APA position statements are policy documents approved by APA's Assembly and Board of Trustees and define APA policy on specific topics. The position statement on reactive attachment disorder is posted on APA's Web site at <www.psych.org/archives/200205.pdf>. ■

Next *DSM*

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malfunctions are occurring, the underlying mechanisms or pathophysiology of mental disorders, the expected course of disorders, the effect of environmental and cultural influences on disorder expression, and the likely response to treatment. We will plan to assess the status of multiple research field contributions to this effort over the next five years before the diagnostic work groups are assembled to revise the *DSM*."

Regier also said that he hopes that the monograph will stimulate research in other countries with a substantial research capacity. "Hence," he said, "we will be presenting a prototype conference on depression at the World Conference of Psychiatry in Japan this month."

A Research Agenda for DSM-V ***may be purchased from the American Psychiatric Publishing Inc. by calling (800) 368-5777 and asking for item number 2292; ISBN 0-89042-292-3. It may also be purchased online at <www.appi.org>.*** ■

Size of Hippocampus Has Implications for Depression

An abnormally small hippocampus is implicated in major depression and appears to be a risk factor for depression, not a consequence of it. But whether the small hippocampus results from stress, genes, or other factors is yet to be determined.

BY JOAN AREHART-TREICHEL

Since Alzheimer's disease ravages human memory, it's hardly surprising that the brain's major memory center—the hippocampus—has been found to be smaller than normal in Alzheimer's patients *(Psychiatric News*, September 1, 2000*)*. But how about major depression? Memory loss is not a prominent symptom of this disorder. Still, an abnormally small hippocampus appears to be involved in major depression as well.

In 1999, for instance, Yvette Sheline, M.D., an associate professor of psychiatry at Washington University, and colleagues reported that women who had experienced recurrent major depression had hippocampi that were smaller than normal. And now abnormally small hippocampi have been noted in persons experiencing a first episode of major depression.

This new finding, from psychiatrist Thomas Frodl, M.D., and colleagues from the psychiatry and radiology departments at Ludwig-Maximilians University in Munich, Germany, is reported in the July *American Journal of Psychiatry*.

Frodl and his coworkers recruited 30 patients with a first episode of major depression for their study. Psychiatric diagnoses based on *DSM-IV* criteria were determined by a consensus of at least two psychiatrists. The average time that the subjects had had their depression was nine months. For comparison, 30 healthy subjects were matched in a one-to-one fashion with respect to age (mean age 40 years), gender, education, daily alcohol consumption, and other factors.

Frodl and his team then took pictures of the 60 subjects' hippocampi with high-resolution magnetic resonance imaging and then compared the findings for the depressed subjects with those for the control subjects.

Male depressed subjects had significantly smaller hippocampi total volumes and hippocampal gray matter volumes than the control subjects did, the researchers found. And both male and female depressed subjects showed significant reductions in hippocampal white matter compared with the control subjects.

So if abnormally small hippocampal architecture is implicated in depression, what actual role is it playing? As Alan Schatzberg, M.D., chair of psychiatry at Stanford University School of Medicine, pointed out in an accompanying editorial, "The fact that [this latest] study involved first-episode patients suggests that a smaller hippocampus, particularly in men, is a risk factor for, rather than a consequence of, major depression."

Frodl and his team agree. As they wrote in their study report, the "findings support the hypothesis that the hippocampus and its connections within limbic-cortical networks may play a crucial role in the pathogenesis of major depression."

And if a smaller hippocampus plays a causal rather than consequential role in depression, how did the hippocampus become abnormally small in the first place? One possibility is stressful life events. After all, stressful life events are well known to be capable of triggering depression; animal studies have linked prolonged stress with a smaller hippocampus, and persons with posttraumatic stress syndrome have a smaller hippocampus than normal (*Psychiatric News*, May 19, 2000). In fact, Frodl and his coworkers went so far in their study report to suggest that stressful events early in a person's life might impair the hippocampus and that this damage might then predispose the individual to depression later in life.

Still another possibility, Schatzberg pointed out in his editorial, is that a smaller hippocampus results from inheritance, not stressful life events. Several studies point to a strong genetic influence on hippocampal volume. For instance, Schatzberg and his colleagues explored, in monkeys, the relative contributions of early life stress and genetics to hippocampal size in young adulthood. Genes—not early stress—appeared to account for much of the variance in hippocampal size.

The study by Frodl and his team was financed by the German Federal Research Ministry.

The study report, "Hippocampal Changes in Patients With a First Episode of Major Depression," is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/159/7/1112?>. ■

Parity

continued from page 1

ence between managing benefits and short-changing patients."

What followed was a hearing punctuated by harsh questions from committee members to witnesses testifying against parity. Most of the subcommittee members, Bilirakis noted, are cosponsors of HR 4066.

How Much Does It Cost?

The Congressional Budget Office (CBO) clarified in a July 12 memo its previous estimate that parity would result in an average increase of 0.9 percent in health plan premiums.

CBO noted that many plans would experience no additional cost, either because their health plans already meet the requirements of the bill or because they do not offer any mental health benefits, thus being exempt from parity requirements. However, CBO said that those plans that offer some mental health benefits and use "benefit design elements that would be prohibited under the bill" could experience greater cost increases to provide those benefits under the proposed legislation. "We estimate that. . .affected plans would experience an increase of between 30 percent and 70 percent in their mental health costs," stated the CBO memo.

Charles M. Cutler, M.D., chief medical officer of the American Association of Health Plans, which represents group health plans covering approximately 170 million people nationwide, immediately discounted the CBO estimate of 0.9 percent, saying that it does not "reflect the true costs of the bill."

Cutler cited other studies showing average cost increases of 3 percent to 4 percent. He argued that covering all disorders recognized in *DSM* would significantly inflate these numbers, causing treatment for conditions such as "jet lag" and "caffeine intoxication" to be subject to payment.

'Red Herring' Arguments Shot Down

APA's Regier testified next. He countered that the cost of not covering mental health benefits is even more expensive to American consumers and businesses.

In fact, Regier said, lack of parity is "a market failure that allows insurers to 'race to the bottom' in an effort to avoid risk"—a reference to plans that opt to offer minimal, cut-rate benefits at the lowest cost and risk to the plan.

"This is the antithesis of the free market and penalizes responsible employers who cannot take advantage of competition. Insurers may profit in the short term, but businesses and the public sector are clearly burdened."

Regier strongly countered attacks on *DSM*, calling them "red herrings." The attacks, he said, focus on peripheral conditions and falsely assert that parity would result in an explosion of claims for such conditions.

"Parity opponents know full well," Regier testified, "that *DSM* requires evidence of clinically significant impairment that would be fully protected under the House and Senate parity bills. The debate over *DSM* is palpably false and designed to distract Congress from the real issue: blatant insurance discrimination against patients with mental illness."

California Rep. Anna Eshoo (D) strongly rebukes opponents of parity during their testimony before a House subcommittee, telling them to simply "answer the question, gentlemen. Yes or no? Do you support disparity?"

Regier was followed by Neil Trautwein, director of employment policy for the National Association of Manufacturers. Trautwein not only argued that HR 4066 is too expensive and would result in mandated coverage of conditions that "have no basis in medical science," but also pointed out that the medical-necessity provisions of the bill would result in increased litigation surrounding denied claims.

Following Trautwein, James Hackett, president of Houston-based Ocean Energy, testified that his company, along with a large realty investment company and the *Houston Chronicle*, implemented full parity for *DSM* disorders in the last year.

"Each of us," Hackett said, "has estimated that any increase in cost due to parity will be minor and more than offset by avoided costs of lost employee productivity."

He urged the subcommittee to support the bill. "While I personally believe as a business leader that providing mental health benefits on par with physical health benefits makes not only economic but moral sense, there is a need for governmental intervention to end insurance discrimination against mental illness," he said

Bilirakis began the questioning period of the hearing by submitting to Regier a set of written questions, asking APA to provide the subcommittee with written answers as soon as possible.

Cutler and Trautwein were harshly questioned by several members, including Norwood, who tried repeatedly to get Cutler to describe the mental health benefits in a typical plan offered by his association's members. Cutler responded that 96 percent of the members already provide some mental health coverage, but was evasive when pointedly questioned to describe the actual coverage, saying only that HR 4066 would significantly increase costs.

"If 96 percent of your member plans are covering it, what you're testifying to," Norwood argued, "is that you ain't covering it very well!"

Rep. Anna Eshoo (D-Calif.) sternly rebuked both Cutler and Trautwein when she believed they were being evasive in answering questions regarding whether they supported the fundamental concept of parity.

"Just answer the question for the record, yes or no—although your answer may be uncomfortable for you, and it must be, because I don't think your stand is one that the American people in business today support—and that is, you are for disparity," she said. "We're here today trying to move things into the equal column, and from your testimony, what we can make of it, you are for disparity."

Chances for Passage

Bilirakis concluded the day's hearing with comments that were optimistic, yet guarded. "I think that the feelings and position of the members of the committee are pretty evident here today, and that is a definite willingness to work on this subject," he said. "I am optimistic we can do so with a mind toward compromise."

APA Division of Government Relations Director Jay Cutler, J.D. (no relation to AAHP's Cutler), later summed up his impression of the hearing. He said that he was optimistic but mindful of the existing challenges to the bill's passage.

"There were clear signals at the hearing that reinforced a strong interest in wishing to pass legislation this year, if an acceptable legislative compromise could be worked out," he said. "We must recognize that politics is the art of compromise, and psychiatry is exquisitely aware that the devil is in the details."

With limited time remaining on the legislative clock this year, he said, getting an acceptable compromise to Bush for his signature would be "most challenging."

Regier's testimony is posted on the Web at <www.psych.org/pub_pol_adv/ecparity72302.cfm>. More information on the hearing is posted at <http://energycommerce.house.gov/107/hearings/07232002Hearing671/hearing.htm>. ■

Institute Offers Update on Psychiatric Factors in HIV

Register now for one of the most important sessions at APA's fall institute.

Enormous mental health challenges face a patient with HIV/AIDS. Studies estimate that as many as 75 percent of all AIDS patients will show symptomatic central nervous system consequences. It is vital for mental health providers to have access to training programs and materials to provide the best possible care for the HIV patient.

In collaboration with the University of Illinois and the Midwest AIDS Education and Training Center, APA's Office of HIV Psychiatry will offer a full-day neuropsychiatric course at the 2002 Institute on Psychiatric Services in Chicago. The course, titled "The Recognition and Treatment of the Psychiatric Dimensions of HIV/AIDS," will be held Friday, October 11, from 9 a.m. to 5 p.m. Registration will be held from 8 a.m. to 9 a.m.

As part of the morning sessions, participants will receive the latest medical update on HIV including epidemiological findings and current HIV treatment modalities and an overview of the neuropsychiatric aspects of HIV infection. There will also be review of clinical and treatment issues affecting those who are triply diagnosed with HIV, mental illness, and substance abuse.

During the lunchtime presentation, participants will be able to discuss the issues regarding risk patterns and challenges to HIV prevention and risk reduction for patients with mental illness.

The afternoon sessions will begin with a presentation about working with specific populations. This will be followed by a panel of HIV-positive individuals who will share their perspectives regarding HIV psychiatric assessment and treatment issues. They will discuss their personal experiences with mental health professionals, including challenges they have faced and suggestions for how mental health professionals could better meet their needs. The day will end with an interactive case discussion.

The deadline to reserve space in this course is September 27. Reservations may be made by contacting the Office of HIV Psychiatry by phone at (202) 682-6147 or by e-mail at cpeggs@psych.org. ■

Come to IPS's Exhibit Hall for Coffee, Chatter, And Prizes

The Exhibit Hall will be the central gathering spot at APA's 2002 Institute on Psychiatric Services.

APA's Institute on Psychiatric Services is an informal, practical, multidisciplinary meeting with a clinical focus that offers attendees excellent educational sessions and—and just as important—the opportunity to network with colleagues, both nationally and internationally.

To facilitate that interaction, the institute features a central gathering point—the Exhibit Hall, which will be located this year in the Upper Exhibit Hall on the fourth floor of the Palmer House Hilton Hotel.

The Exhibit Hall will be the site of morning coffee breaks and afternoon receptions. Commercial and educational exhibitors will be available to disseminate information on the latest products and services for psychiatrists and mental health professionals. In addition, APA staff will be on hand in the APA Resource Center to answer questions and provide handouts on many topics, and psychiatrists seeking new positions and employers will find the services of the APA Job Bank indispensable.

Registrants will be eligible to win prizes at morning and afternoon drawings. This year's prizes include a notebook computer, Palm Pilot, personal copy machine, fax machine, cordless phone, DVD player, digital camera, stereo, free registration for APA's 2003 annual meeting in San Francisco, free registration for the 2003 institute in Boston, two nights' lodging at the Marriott Copley Place (the site of the 2003 institute), free dinners, and two roundtrip domestic airline tickets.

The exhibits will open at 1:30 p.m. on Thursday, October 10, and close at 5:45 p.m. on Saturday, October 12. ■

Register Now!

There are two easy ways to register for APA's Institute on Psychiatric Services, which is being held in Chicago October 9 to 13:

- Register online on APA'S Web site at <www.psych.org/sched_events/ips02/index.cfm>
- Request a preliminary program from the APA Answer Center at (888) 357-7924. The program contains hotel information and registration forms.

Save on fees by registering before September 9.

Resident Summit To Focus on Interactions With Drug Industry

Residents can learn how to interact ethically—and on their own terms—with pharmaceutical company representatives.

At APA's fall Institute on Psychiatric Services, residents are invited to attend a summit on interactions with the pharmaceutical industry. As many residents know, physician contact with the pharmaceutical industry is frequent during residency training.

Michael Jibson, M.D., director of psychiatry residency training at the University of Michigan in Ann Arbor, has created a curriculum to help residents construct an ethical framework in which to evaluate these interactions. The session, titled "An Ethical Framework for Physician Interactions With the Pharmaceutical Industry," will be held Friday, October 11, from 1:30 p.m. to 3 p.m. in Parlor B, sixth floor, Palmer House Hilton.

The session is intended to educate residents about the nature and impact of the pharmaceutical industry on the practice of medicine, examine the nature of interactions between physicians and industry, clarify the ethical issues involved in physician-industry interactions, and assist residents in evaluating the ethical and clinical implications of physician-industry interactions.

The session is designed to avoid a polemic approach in favor of a balanced consideration of the issues involved. The goal is for residents to develop informed, clear, and thoughtful standards for these interactions. Participants will also have an opportunity to discuss their experiences and ask questions.

More information is available by contacting Nancy Delanoche by phone at (202) 682-6126 or by e-mail at ndelanoche@psych.org. ■

members in the news

O'Reardon

continued from page 9

from his office to a small room nearby where subjects come for the experimental treatment. Each subject sits in the large, comfortable, green vinyl chair while O'Reardon uses the electromagnetic coil to generate the magnetic field that stimulates the subject's brain.

O'Reardon gives subjects who respond favorably to rTMS what is known as a "serotonin stress test." This is a test to see whether the neurotransmitter serotonin was involved in their rTMS treatment response.

If it turns out that serotonin is involved in the response, O'Reardon explains, that discovery would help clinicians provide more effective treatments to patients with treatment-resistant depression. For instance, if it turns out that rTMS counters depression by stepping up the production of serotonin, then patients who respond only partially to rTMS probably do so because their depression is only partially due to a serotonin deficiency. In that case, giving them not just rTMS but a medication that increases production of another neurotransmitter in their brains—say, norepinephrine—might possibly be just the combination needed to banish their depression.

"My goals," O'Reardon concludes as he bids his visitor goodbye, "are to better understand how rTMS and other therapies for treatment-resistant depression work. And I also want to collaborate with other investigators to develop combined treatments for treatment-resistant depression, including psychotherapy as well as biological treatments like rTMS and medication, since treatment-resistant depression afflicts a huge number of individuals.

"People say, 'It must be depressing to research treatment-resistant depression.' But I say, 'It's a lot of fun because every subject is different, always a challenge.' And when you help them, it's immensely rewarding because they have been suffering for a long time." ■

letters to the editor

Readers are invited to submit letters not more than 500 words long for possible publication. Submission of a letter implies consent for publication unless otherwise indicated. All letters are subject to editing to meet style, clarity, and space requirements. Receipt of letters is not acknowledged. Send submissions to Letters to the Editor, *Psychiatric News,* at 1400 K Street, N.W., Washington, D.C., 20005; fax: (202) 682–6031; e-mail: pnews@psych.org.

Opinions expressed in letters do not necessarily reflect the views of APA or the editors. Clinical opinions are not peer reviewed and thus should be independently verified.

Lifers Take Stand

In February 2000, following news reports of misuse and abuse of psychiatry in the People's Republic of China, I lodged a formal complaint with the World Psychiatric Association.

WPA procedures call for an investigation of such complaints by its review committee. However, notwithstanding the fact that accusations of increasingly serious human rights violations in China are being reported, especially allegations that nonmentally-ill Falun Gong practitioners are being subjected to unwarranted psychiatric interventions including the administration of high-dose, long-acting neuroleptic drugs, the WPA has moved with glacial speed in addressing this problem.

Thus, it is most gratifying that the APA Lifers at its annual business meeting on May 20 unanimously adopted a resolution calling on APA to persuade the WPA to conduct its planned investigation of abuse of psychiatry in the People's Republic of China without further delay.

ABRAHAM L. HALPERN, M.D.
Mamaroneck, N.Y.

President's Column

Regarding Dr. Paul Appelbaum's column in the July 5 issue titled "Throw Them Out?," I find his discussion of our collaboration with the drug companies a specious line of reasoning that tells me that (1) we have been bought and paid for by them and (2) much of our substance as an organization would collapse without their money.

Let's face the fact that we have rationalized a corrupt relationship to these profit-seeking companies since time immemorial and lack the guts to cleanse ourselves to restore our ethical standing. Unless we face up—and, yes, throw them out—we will continue to be the spineless organization that we are.

F. ROBERT RODMAN, M.D.
Beverly Hills, Calif.

Dr. Appelbaum, thanks for your piece in the July 5 issue of *Psychiatric News*. It is some comfort that APA has been exercising control over what drug companies present at our annual meetings. We should expect all of our members, especially those on the staffs of hospitals, to build a wall between themselves and the drug companies.

To start: let us recommend (and if that does not work, condemn) that no psychiatric staff accept lunch money from a drug company. If we cannot afford to pay for lunch, we should apply for welfare (a few more increases in malpractice premiums, increases in the cost of state licenses, and decreases in insurance company compensation might make that necessary). At any rate, we should not be beholden to the drug companies.

KENNETH H. GORDON JR., M.D.
Radnor, Pa.

I am a pharmaceutical whore. I do not follow the advice of our president, Dr. Paul Appelbaum, who suggests that we refrain from accepting the trinkets—the pens and the calendars emblazoned with the logos of the pharmaceutical products—and instead ask for reprints of controlled studies from peer-reviewed journals of the products in question.

I do just the opposite. Pharmaceutical reps who visit my office know that I am eager to receive only what we call "the toys" and that I will not even glance at the latest "controlled study." I take the toys and give them to my children in New York City, who consider it cool to serve Risperdal popcorn to their East Village friends. All right, I admit it: I keep the Prozac pens because they write better than a Mont Blanc. And I go to the dinners at the best restaurants in Providence, because I like a good veal chop. I sit with like-minded friends, and we do our best to be ungrateful guests by quoting studies from "refereed journals" about a competing drug that we have heard about over a prime steak the month before.

Yes, I am a whore. Mea maxima culpa. But I won't accept the articles. I know that in the fine print at the bottom of each one of them, there is the modest disclaimer that "this study was financed by an unrestricted grant from the XYZ company." And I know that the pages of the refereed journal in which these articles appear are filled with full-page color ads from the very pharmaceutical companies that sponsor the research. And I know that the researchers who write these articles depend on pharmaceutical largesse for their livelihoods and for the support of their academic departments.

Dr. Appelbaum's article is a wonderful apologia for APA and its relationship with the pharmaceutical companies. What it boils down to is, "We take their money because we need it." The costs to APA of publishing the *American Journal of Psychiatry* would soar. We do our best to monitor the scientific validity of the breakfast symposia, because if we didn't allow them to buy their way into our meetings, they would hold them elsewhere, without our scrutiny and control. Have you ever attended a breakfast symposium sponsored by a pharmaceutical company that touted the superiority of its competitors?

Now, let me get this straight. I should not accept ballpoint pens from pharmaceutical companies, but APA can accept millions and millions of dollars each year? Yes, I'm a whore, but just a two-bit whore. APA does it with class.

MICHAEL A. INGALL, M.D.
Providence, R.I.

The article "Drug Industry Responds to Complaints About Marketing" and "Throw Them Out?" by Dr. Appelbaum in the July 5 issue make some interesting points. But why should we physicians give our time free of charge to pharmaceutical companies when their sales reps call on us or when we attend their presentations, the sole purpose of which is marketing their products?

Yes, Dr. Appelbaum is right. My time is worth a lot more than pens, note pads, and frisbees! We should charge for our time when reps call on us and when we attend industry-supported presentations. That includes attending industry-supported presentations at APA's annual meeting. There is nothing unethical about charging for our time.

DEV CHACKO, M.D.
Orlando, Calif.

I regard Dr. Appelbaum as a shining light of our profession, but in his presidential column of July 5 titled "Throw Them Out?," he misses the point of objections by some APA members to the incestuous relationship between our organization and pharmaceutical companies.

Not only psychiatry, but all of medicine is under scrutiny about these relationships. The editorial pages of the *New England Journal of Medicine* and *Lancet* have deplored the damage that they cause to organized medicine and have called loudly for change. Even among some of my psychiatric colleagues, there is a perception that the recommendations of experts, and even the fruits of research, have to be regarded with skepticism because of the potential bias induced by financial and professional ties with drug companies. But we are told, nevertheless, that accommodation to the status quo by APA is practical and wise: that drug company-supported educational programs are necessary, that the selection of material is completely independent, and that APA would be unable to carry out many of its essential functions without drug company financing.

In accepting such rationalizations, we risk losing our most valuable asset: our reputations for independent judgment and the uncompromising devotion to patient care above all other concerns. By indebting ourselves to these commercial interests, we will lose the public's trust in our professional objectivity, not to mention losing some of our self-esteem.

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The article "Drug Industry Responds to Complaints About Marketing" and Dr. Appelbaum's column "Throw Them Out ?" fail to consider that many psychiatric and medical residents have huge debts and often have less than $100 a month disposable income. They also suffer from major stresses producing PTSD symptoms in them and their families, according to J.J. Cohen in "Heeding the Plea to Deal With Resident Stress" in the March *Annals of Internal Medicine*.

To them, drug company dinners, pens and pencils, honoraria, and so on might help temper the cruelties inflicted by the current business management of medicine. We really ought to encourage pharmaceutical companies to cater to interns and residents and their families in any way possible.

In addition to the usual offerings, I would propose that these companies set up a fund to help needy interns and residents repay their loans. This could lead to a $.50 per prescription tax whose purpose would be

please see ***Letters*** *on facing page*

Dr. Appelbaum Responds

If additional evidence were needed of the divergent opinions among our members regarding relationships with pharmaceutical companies—as well as the passions evoked by the topic—these letters offer conclusive proof. Should we as a profession refuse to have anything to do with the drug companies or is our greatest failing as a profession that we are neglecting to squeeze as much money from them as we can? Are the brightly colored trinkets dispensed by the pharmaceutical detailers appropriate tokens of love for our offspring or dangerous lures that threaten our independence and devotion to our patients' needs? Write your prescriptions and make your choice.

Amid this welter of conflicting individual opinions, APA must define a reasonable policy for a professional organization. That task is complicated by the recognition—at least insofar as our annual meeting is concerned—that our failure to provide space within the meeting for pharmaceutical displays on the exhibit floor and industry-supported symposia in the program will simply mean that these activities will take place nearby in competition with our meeting and in ways over which we have no control. Whatever the virtues of ideological purity, and it has its place, the compromise that brings these activities within the meeting and subjects them to guidelines and appropriate oversight (as described in my July 5 column) seems to me to be a reasonable one.

How about our other relationships with the industry? APA accepts industry support for educational programs such as fellowships for residents, newsletters for our members, and other special projects. As long as those donations come with no strings other than a discreet acknowledgment—which they do—I see no problem with them. Pharmaceutical companies and others advertise in our journals and in this publication; in a world suffused with advertising, where SSRIs are marketed to the public on primetime TV, it seems difficult to identify the harm that permitting such advertising might cause. Just as members are free to avoid the pharmaceutical exhibits at the annual meeting, they are at liberty to page past the advertisements in our journals.

Could APA exist without any money coming into its coffers from the pharmaceutical industry? Of course it could: it would be a much smaller organization, and the tasks it could undertake would be much more limited.

But I have served as president of a psychiatric subspecialty organization that gets essentially no revenue from the pharmaceutical industry and manages its limited role very nicely indeed. The question is one of costs and benefits. What is to be gained from abandoning our carefully calibrated relationship with the drug companies, that is, in what way would we be a better organization by doing that? And are those gains greater than the losses we would suffer in becoming an organization without the means to engage in public information, advocacy, and educational activities? I think the burden is on those who would alter the status quo to explain to us clearly why that is worth doing.

Finally, I have been impressed over the years with the possibility of discussing even the most complex and charged topics in a tone of civility.

To my surprise, it has usually turned out that those who favored other approaches than those I would support were as well intentioned in their efforts as I imagined myself to be. This conclusion, along with the recognition that civil and even understated argument often exceeds in impact its more fervid counterpart, has usually led me to forgo the enormous pleasure associated with calumniating those who differ with me. Clearly, this is not a universally accepted proposition—but I offer it for whatever it may be worth.

from the president

continued from page 3

grams have continued closing beds and imposing new restrictions on eligibility for services. Private sector insurance programs almost universally have carved out their mental health care, turning it over to the less-than-tender ministrations of the managed care industry. Managed care's progressive reductions in payments to practitioners and facilities have forced a steady shrinkage in the number of inpatient units and outpatient clinics, and in the availability of private practitioners who accept insurance coverage in exchange for care. Taken as a whole, these changes have led to a crisis of access in many parts of the country, the consequences of which include tens of thousands of persons with mental illness confined in jails and prisons, acutely ill patients waiting for days in emergency rooms for inpatient beds to become available, and waiting lists of weeks to months for outpatient care.

Even more frightening than merely recounting this litany of failure is the recognition that this systematic defunding of psychiatric care occurred during the most sustained and—dare I say—exuberant period of prosperity this country has known. Now, in a very different economic climate, things are going to get only worse.

The abject failure of managed care to constrain the increase in medical care costs for more than a few years means that businesses are seeing annual increases in their health insurance premiums of 10 percent to 30 percent or more in some areas. Employers are agitating for the ability to provide stripped-down benefit packages at reduced cost—with mental health coverage the first element to be stripped away. Alternatively, businesses are looking to shift more of the cost of health care to patients, by increasing the share of premiums that workers must pay and raising deductibles and copays. With mental health care more price sensitive than other forms of treatment, access to psychiatric services is likely to be affected disproportionately. Finally, we ought not to forget that some employers—especially smaller enterprises—are simply canceling all coverage for their workers, leaving them with no assistance whatsoever in meeting the costs of medical care.

If the public sector once offered a safety net for persons unable otherwise to access psychiatric care, that net itself is beginning to give way. The current economic slowdown, combined with a stock market in free fall, has led to a dramatic reduction in state revenues. Budget gaps in our larger states are projected in the several billions of dollars, as treasuries stagger under the combined impact of reductions in business income taxes and all-but-nonexistent revenues from capital gains. As cuts need to be made to balance state budgets, legislators and governors are looking to reductions in Medicaid funding—the largest or second largest budget item in most states—and to decreases in traditionally less popular departments, including mental health.

Thus, at the same time that fewer people will be able to cover the costs of psychiatric care from private insurance, it will be harder to obtain Medicaid, and fewer directly operated public services will be available. With pressure on care providers increasing as the number of uninsured patients grows, and as already inadequate Medicaid and managed care payments fail to keep up with the rate of inflation or are actually reduced, more hospitals will decide to close money-losing inpatient units, more clinics will throw in the towel, and more clinicians will opt for the private-pay market or look for other ways to make a living.

We cannot allow this to happen. A viable mental health system cannot survive if it is inadequately funded when times are good and then brutally slashed when the economy turns sour. With data indicating that fewer than half the people in this country with clinically significant psychiatric disorders receive any treatment as it is, there is no room to allow things to get worse.

Here is where the new Commission on Mental Health comes in. If it accepts its reported mandate of merely reshuffling the pieces on the mental health services chessboard, it will prove of no value whatsoever. There is no solution to the current problems that will not require more resources. The commission cannot fulfill its moral obligation to the people of this country who suffer from mental illness without saying this loud and clear. Whatever specific proposals it might make for improving mental health services, the commission must call attention to the ways in which defunding is creating a crisis in access for our patients.

Not all commissions are fated to have their reports filed and forgotten. In the late 1950s, during another Republican administration, the Joint Commission on Mental Health and Mental Illness produced a series of historic reports, culminating in Action for Mental Health in 1961. This report led to the Community Mental Health Centers Act of 1963—the first effort to develop a genuine system of mental health care in the United States. The New Freedom Commission would do well to keep this legacy in mind and rise to meet its own historic opportunity. ■

letters to the editor

continued from page 25

to eliminate residents' debts. In exchange, the payers would be creating a beneficence for themselves with the coming generation of practitioners. Who would not like to be able to say to their young physician, "I helped put you through school"? It might reinforce the ties between patient and doctor, which are currently impeded by business interests. Any takers?

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