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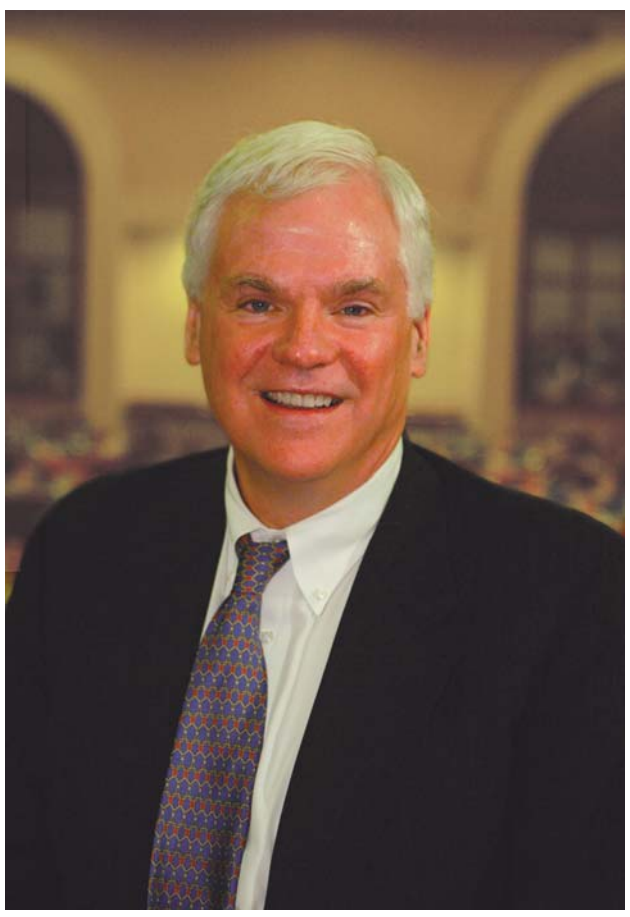
Board Taps APA Veteran To Be Next Medical Director

James Scully, M.D., vows to confront APA's significant challenges head on and strive to make the Association "the premiere medical specialty organization" in the country.

BY JIM ROSACK

APA's Board of Trustees has selected James Scully, M.D., as the next medical director of the Association, replacing Steven Mirin, M.D. The pair is working closely to ensure a smooth transition, which should take place in December.



James Scully, M.D., participated in APA's fall component meetings last month in Washington, D.C., where the announcement of his appointment was first made.

APA President Paul Appelbaum, M.D., made the announcement last month at the plenary session of the fall component meetings in Washington, D.C.

"We are absolutely delighted that Jay Scully will be the next medical director of APA," Appelbaum told *Psychiatric News*. "He is probably the single most qualified person in the United States to assume this role, having served as [APA] deputy medical director, a training director, a department chair, and a member and director of the American Board of Psychiatry and Neurology. He has been at the nexus of all of the major issues in contemporary psychiatry. We are very lucky to have him."

Mirin told *Psychiatric News* that he was also very pleased at the choice of his successor and looked forward to working with Scully to effect a comfortable transition.

Mirin added, "It is a tribute to the members of the search committee, headed by Dr. Herb Pardes, that they were able to present such a well-rounded candidate, by virtue of his training, background, and experience, to the Board for its approval."

"I'm very excited to be coming home," said Scully, currently the Alexander G. Donald Professor and chair of the department of neuropsychiatry and behavioral science at the University of South Carolina School of Medicine. He is no stranger to either the Washington, D.C., area or to APA. He grew up in Washington, D.C., and from 1992 to 1996 was a deputy medical director of APA and director of its Office of Education.

He also is an APA fellow and the senior delegate and chair of APA's delegation to the AMA, as well as a member of the Task Force on Competency in Graduate Education. He is a director and treasurer of the American Psychiatric Institute for Research and Education (APIRE). He has been an active member of the Colorado Psychiatric Society, the Washington (D.C.) Psychiatric Society, and the South Carolina Psychiatric Association, as well as the South Carolina Medical Association and the AMA.

Scully is also a member of the Residency Review Committee for Psychiatry and chair of the Education Committee of the American College of Psychiatrists. He is the author of more than 30 journal articles, chapters, and book sections and has edited each of the four editions of *Psychiatry*, published by Lippincott, Williams, and Wilkins.

In addition to his current appointments at the University of South Carolina, he is director of the division of education, train-

please see ***Scully*** *on page 28*

Petition Candidates

Any member wishing to be nominated by petition is urged to contact Carol Lewis immediately by phone at (888) 35-PSYCH, ext. 6063, or (202) 682-6063 or by e-mail at clewis@psych.org. Signatures of 400 voting members (100 for area trustees and member-in-training trustee-elect) supporting the nomination must be filed with the APA secretary by October 15. Biographical and campaign materials for publication in *Psychiatric News* and for distribution with the ballot are also due by this deadline from all candidates.

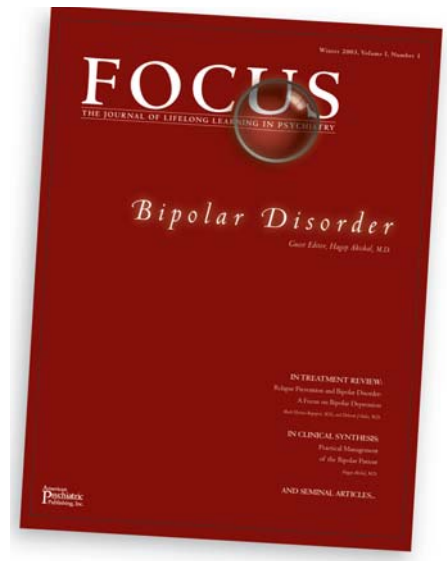
New APA Journal Supports Lifelong Learning Activities

APA is launching a new peer-reviewed journal to help members stay on top of the latest information on a wide range of psychiatric disorders while touching upon complex issues such as ethics and HIV.

BY EVE BENDER

A new and holistic approach to medical education is moving physicians away from lifetime certification toward "maintenance of certification," and from continuing medical education (CME) toward "lifelong learning." APA's new peer-reviewed journal, *FOCUS, The Journal of Lifelong Learning in Psychiatry*, should ease

please see ***New Journal*** *on page 28*



APA's new journal, *Focus,* is a primary tool that psychiatrists can use to maintain board certification.

Program Tailored to Troubled Youth Reduces Recidivism, Saves Money

An award-winning Milwaukee program produces dramatic results by bringing resources to families instead of sending children to institutions.

BY KATE MULLIGAN

In 1994 the Milwaukee County Human Services Department received a five-year grant from the Center for Mental Health Services (CMHS) to bring about system reform in the provision of mental health services to youth with severe emotional needs and their families.

That grant resulted in the 25 Kid Project, which was targeted to 25 youth who had been placed in residential treatment centers. When the project started in 1996, more than 360 young people were in placement each day in the county at a cost of more than $18 million a year.

The goal of the pilot project was to demonstrate that these children could be successfully returned to their homes or those of relatives and maintained there at a cost less than that of residential treatment.

Project team members offered each child and family an individualized package of services tailored to their specific needs.

Within 90 days, 17 of the youth were returned to the community. Eventually, seven entered foster homes, and the remaining 17 were successfully returned to their families. Only one youth could not be returned to the community.

By 1998 the program, named Wraparound Milwaukee, had expanded to 650 youth and begun to demonstrate impressive results.

Bruce Kamradt, director of the Children's Mental Health Services Division for Milwaukee County, wrote in the May-June 2000 *Juvenile Justice* that the use of residential treatment had decreased 60 percent since Wraparound Milwaukee had begun. Inpatient psychiatric hospitalization had dropped by 80 percent. The average overall cost of care per child had decreased from more than $5,000 a month to less than $3,300 a month.

The average score on the Child and Adolescent Functional Scale improved significantly. The average score at the time of enrollment was 74, at the high range of impairment. One year after enrollment it was 48, a moderate level of impairment.

Recidivism rates also showed improvements across six measures, such as assaults and drug offenses.

The philosophy behind this success story sounds simple.

Milwaukee Wraparound's Medical Director Clarence Chou, M.D., told *Psychiatric News*, "We look for reasons to keep kids with their families instead of trying to find justifications for taking them away. We think they are better served when the family receives treatment and services together than when the child is treated alone in an institution."

The youth are in the program as a result of court action.

Implementation of this concept, however, requires coordination of the work of 230 agencies offering 80 services. These include such services as mentors, tutors, respite care, and transportation, as well as more conventional services such as family therapy and inpatient psychiatric care.

Care coordinators, who work with a ratio of one coordinator to eight families, are key to the success of the program. A coordinator works with a family to identify their nat-

please see ***Troubled Youth*** *on page 38*

Priority Hotel Reservations For APA Members

Priority hotel reservations for APA's 2003 annual meeting in San Francisco are available during the month of December for APA members.

As an additional member benefit, housing for the 2003 annual meeting will be open to **members only** on Tuesday, December 3. Your membership number is needed to make advance hotel reservations and should be noted on all correspondence.

To make the process as simple as possible, you may register in the following ways:

- **Online at <www.psych.org>.** Click on "Members Corner" and log in, and then click on "2003 Annual Meeting" and follow housing link to Travel Planners Inc.
- **Phone at (800) 221-3531 or (212) 532-1600.** Lines are open Monday through Friday from 9 a.m. to 7 p.m. Eastern time.
- **Fax.** To reserve fewer than 10 rooms, fax to (212) 779-6128; to reserve 10 rooms or more, fax to (212) 779-6134.
- **Mail at Travel Planners Inc., 381 Park Avenue South, Third Floor, New York, N.Y. 10016.**

from the president

Here Comes 'Lifelong Learning'

BY PAUL APPELBAUM, M.D.

Continuing medical education, or CME for short, is a rubric with which we all have become familiar over the years. A given number of CME credits are required by state boards for relicensure, hospitals for recredentialing, and many professional societies for membership renewal. The goal of CME is to ensure that physicians keep up with the rapidly changing evidence base for clinical practice after they leave their specialty training programs.

Though the goal is worthy, the means of achieving it are flawed. Merely counting the number of hours of lectures and panels that a physician has sat through offers no guarantee that the physician actually has absorbed the information presented—much less that he or she will apply it in practice. Moreover, a physician need not be exposed to the CME material in any systematic fashion. An enterprising CME'er can leap randomly from topic to topic, perhaps even attending sessions exclusively on areas that he or she knows well while avoiding the more challenging task of learning something new. Indeed, CME credits need not even be obtained in one's own specialty; a psychiatrist could, in theory, fulfill the CME requirement by attending lectures in pediatrics or emergency medicine—however limited their relevance to the psychiatrist's day-to-day work.

Given all of the limitations of the current system, it should come as no surprise that a change is in the works. When APA leaders met earlier this year with the leadership of the American Board of Psychiatry and Neurology (ABPN), we heard about a new approach to CME that was being developed by the American Board of Medical Specialties (ABMS). Along with the new approach comes a new catch phrase. Out with "continuing medical education"; in with "lifelong learning."

What's the difference? Under the ABMS plan, which eventually will be adopted by all member boards, continuing education will be keyed to the specialty recertification process. All psychiatrists certified after October 1994 will need to take a recertification examination every 10 years to maintain their board-certified status. Many who are not required to take the examination may elect to do so anyway as an incentive to undertake a comprehensive review of the field or because a credentialer of some sort has required it. The first recertification exam was given in 2002, and it will be given annually. It is estimated that 500 psychiatrists will need to take the recertification test in 2004, with approximately 1,000 psychiatrists following them each year thereafter.

The ABPN has adopted the ABMS's proposed Maintenance of Certification requirements. At some point in the future, every psychiatrist will need to develop a personal lifelong learning plan and to demonstrate achievement of the plan's goals prior to sitting for the examination.

This will be a new kind of challenge for us all. We will have to identify those areas of knowledge in which we are deficient and target an educational process that will bring us up to speed. Simultaneously, in anticipation of recertification examinations, we will need to stay abreast of the field as a whole in a more comprehensive way than we have had to in the past.

Of course, many psychiatrists do this already. I remember standing in front of the

please see ***From the President*** *on page 38*

JANSSEN PHARMACEUTICA

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Board Votes to Abolish Two Officer Positions

APA Trustees reject a proposal for a dramatic cut in the number of Board members and sign a contract with the new medical director.

BY KEN HAUSMAN

After defeating a proposal to drastically reduce its size, the APA Board of Trustees voted to enact a much smaller cut at its September meeting in Washington, D.C.

Board members were faced with a proposal from the Long-Range Budget and Planning Task Force to limit the number of participants at Board meetings, depending on options chosen. The most contentious of the options would have removed all but one of APA's former presidents from the Board after their three years as a voting member were up. After considerable debate, however, the Board voted to make no change in their status. (Beginning with immediate past president Richard Harding, M.D., whose presidential term began in 2000, APA will stop paying expenses for former presidents to travel to Board meetings after their three years as a voting member end.)

The Trustees did vote to abolish one of the two vice-president positions and to combine the secretary and treasurer positions into one office to be known as secretary-treasurer. They also agreed to seat the nonvoting members at a separate table at the next meeting on a trial basis to see whether this enhances the effectiveness of Board discussions.

As currently constituted, the Board has 21 voting members (see box on page 38). In addition, every former president prior to Harding is entitled to attend Board meetings at APA's expense, though in an ex-officio capacity, that is, without a vote. There are now 23 former presidents, though at most meetings approximately six to 10 attend.

The task force, which is chaired by APA President Paul Appelbaum, M.D., proposed that only the most recent past president be a member of the Board and that individual would have a vote. The task force could identify no other organization that offers lifetime Board membership to ex-presidents, Appelbaum noted.

The task force maintained that the size of the Board "makes discussion unwieldy," Appelbaum explained. "It may take an hour to an hour and a half for every member of the Board to have his or her turn to speak about an important issue," the report pointed out.

That 30 to 35 people sit at the table at most Board meetings "limits the number of issues that can be considered thoughtfully at any meeting," he added. "The time given to nonelected members, however thoughtful their comments, takes time away from those members who have been elected contemporaneously to lead the Association."

The proposal to limit the Board to voting members, the task force concluded, strikes a balance "between a size that allows efficient operation a-+nd the desire to be representative of the membership as a whole."

Most of the Board, however, argued in favor of maintaining the former presidents' ex-officio status. One of those former presidents, Rodrigo Muñoz, M.D., commented that "they have devoted a lifetime to APA in many cases and are a valuable educational resource" for the other Trustees.

Former president Joseph T. English, M.D., insisted that the opportunity to save money, and not, as Appelbaum maintained, the desire for greater efficiency and ease of discussion, drove the proposal.

Responding to Appelbaum's statement that APA appears to be the only organization that keeps every ex-president on its Board for life, Area 1 Trustee Kathleen Mogul, M.D., suggested that "the fact that our Board is different from others is, in fact, a plus, not a detriment." Several Board members pointed out that the experience and wisdom of the past presidents have been valuable in informing Board discussions.

Assembly Speaker Albert Gaw, M.D., said, however, that the Assembly is being asked to downsize "for the sake of better efficiency and cost-effectiveness," and the Board should have to do likewise. The Assembly has already complied with a mandate to cut about 35 percent of its budget in the last few years, he noted. Gaw suggested forming a council made up of former presidents as a way to tap into their knowledge and experience.

Another task force proposal that the Board discussed was to stop inviting the representative of the Committee of Residents and Fellows (CORF) and to have the fellows who are jointly sponsored by APA and pharmaceutical companies continue to attend, since their expenses are paid by the sponsoring companies, but to halt the practice of having them sit at the Board table. There are three such fellows. In addition to the fellows and CORF representative, residents are represented by the elected member-in-training (MIT) trustee, who has a vote, and the MIT trustee-elect, who does not.

Though only one of the six resident positions—that of the CORF representative—would have been eliminated, a substantial majority of the Trustees insisted that approving the proposal would send the wrong message to residents—a group that is a major target of APA's recruitment efforts.

MIT Trustee Susan Padrino, M.D., stated that more, not less, representation by residents is the path APA should pursue. "MITs provide a valuable perspective on many issues," she said, and maintaining their visibility in APA's governance "helps improve the image of the Board" in the view of the residents.

The proposal to eliminate the CORF position passed by a one-vote margin with two abstentions. The vote, however, turned out to be unnecessary because the CORF representative attends as a guest at the request of the president and is not a member of the Board.

The changes that the Board voted in its membership will now go to the APA Bylaws Committee. That committee will draft amendment wording and then report back to the Board.

In other actions, the Board voted to

- **Sign a contract with James Scully,**

please see ***Board*** *on page 38*

Reflections on September 11

After the Board of Trustees observed a moment of silence at its meeting on September 11 in memory of the victims of the terrorist attacks on the World Trade Center and Pentagon one year earlier, former APA president **Joseph T. English, M.D.,** reflected on what the country learned in the short time since those tragic events.

English, who is chair of the psychiatry department at St. Vincent's Medical Center in lower Manhattan and professor and chair of psychiatry and associate dean at New York Medical College, characterized September 11, 2001, as "a day when our country learned of its vulnerability."

"Our vulnerability was but the first lesson of that terrible day," he said. "We were soon to witness the heroic acts of our police and firemen, our ordinary citizens, and a mayor who, the day before, was New York's mayor, but on that day became the world's mayor.

"And what this Board shall do, after these few minutes of reflection, is to return to its work as the governance of a profession, founded by Benjamin Rush, who risked all in signing the Declaration of Independence and who dedicated his life to the pursuit of liberty—liberty from the tyranny of a king and from the chains and stigma of mental illness."

Candidates For APA's 2003 Election Announced

Fred Gottlieb, M.D., and Michelle Riba, M.D., were chosen by APA's Nominating Committee to face off in APA's 2003 election for the office of president-elect. The committee also selected candidates for several other positions on the Board of Trustees.

BY CATHERINE F. BROWN

The APA Nominating Committee announced last month that Los Angeles psychiatrist Fred Gottlieb, M.D., and Michelle Riba, M.D., of Ann Arbor, Mich., will compete in APA's 2003 election for president-elect of APA.

Gottlieb is a child psychiatrist in private practice who treats both families and couples. He previously served APA as Assembly speaker, Area trustee, APA vice president, two-term treasurer, and chair of several councils. As a clinical professor of psychiatry and behavioral science at the University of Southern California, he teaches and supervises child psychiatry fellows. Gottlieb is also a clinical professor of psychiatry at UCLA.

Riba, APA's senior vice president, is the associate chair for education and academic affairs and a clinical associate professor in the department of psychiatry at the University of Michigan and director of the psycho-oncology program at the University of Michigan Comprehensive Cancer Center. Riba is a former APA secretary and trustee-at-large and served as chair of the Scientific Program Committee of the Institute on Psychiatric Services.

The race to be Riba's successor as one of APA's two vice presidents, one of which is elected each year, will pit Norman Clemens, M.D., of Cleveland against Pedro Ruiz, M.D., of Houston. Clemens is currently the Area 4 trustee, and Ruiz is APA's secretary.

The position of APA secretary is also up for election next year, and the candidates are Alfred Herzog, M.D., of Hartford, Conn., and Nada Stotland, M.D., of Chicago. Both are past speakers of the APA Assembly.

The ECP (early career psychiatrist) trustee-at-large, a three-year position, comes up for election as well in 2003. The candidates are Tanya Anderson, M.D., of Chicago and Charles Price, M.D., of Reno, Nev. Anderson is a member of the Committee on Bylaws and a consultant to the Scientific Program Committee. Price is a member of the Corresponding Committee on Private Practice and the newsletter coeditor of the Nevada Psychiatric Association.

The race for member-in-training trustee-elect has three candidates this year: Christopher A. Ramsey, M.D., of New York Presbyterian Hospital/New York State Psychiatric Institute in New York City; Susan D. Rich, M.D., of Georgetown University Hospital in Washington, D.C.; and William C. Wood, M.D., of McLean Hospital in Belmont, Mass.

Three of APA's seven Areas will elect a trustee this year. Facing off in the race for Area 1 trustee are Jack Brandes, M.D., of Toronto and Donna Norris, M.D., of Wellesley, Mass. Competing for Area 4 trustee are Michael Pearce, M.D., of Indianapolis and Sidney Weissman, M.D., of Chicago. The candidates for Area 7 trustee are Nady El-Guebaly, M.D., of Calgary, Alberta, and incumbent Albert Vogel, M.D., of Albuquerque, N.M.

Election ballots will be mailed to all voting members on January 6 and must be returned by February 6. Candidates' biographies and statements will be published in the December 6 issue of *Psychiatric News*. ■

At Work for You …and Your Patients

Approximately 300 APA members arrived in Washington, D.C., last month to participate in the Association's annual fall component meetings and to work on issues of importance to APA and the field of psychiatry and its patients. This marked the first time that the components had met since APA's entire component structure was reviewed and streamlined earlier this year. In an effort led by APA President-elect Marcia Goin, M.D., and Jon Gudeman, M.D., the number of components was reduced from 106 to 88, and the number of positions available went from 654 (plus 232 corresponding members and consultants) to 532 (plus 124 corresponding members and consultants). These reforms reduced the cost of the component structure by about $582,000, or approximately 40 percent. The components also meet in conjunction with the APA annual meeting.

A highlight of this year's fall component meetings was the plenary session held on Friday, September 13 (see page 8). APA President Paul Appelbaum, M.D., introduced APA's next medical director, James Scully, M.D., a former APA deputy medical director and head of APA's Office of Education (see page 1). Also at the session, Appelbaum was pleased to announce that the *Washington Post*—the "hometown paper of every member of Congress," he noted—had reversed its longstanding opposition to parity for mental health benefits in a recent editorial after a crucial meeting with him and other APA leaders and staff.

Changes Put APA on Right Track To Face Future, Appelbaum Says

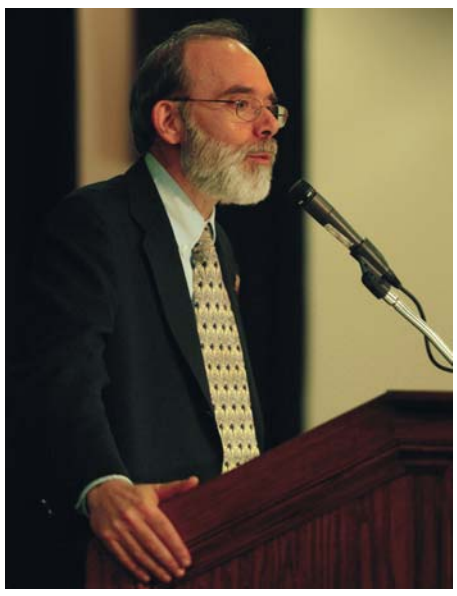
When APA leaders work together toward a common goal, they can accomplish the impossible, and APA President Paul Appelbaum, M.D., demonstrated how at the plenary session of APA's 2002 fall component meetings.

BY EVE BENDER

Heading into the final stretch of 2002, APA stands ready to address the challenges confronting it with a new medical director, a more efficient governing body, and a renewed commitment to fight for mental health parity for all Americans.

This was the message delivered by APA President Paul Appelbaum, M.D., to the leaders and members of APA's components at the plenary session of the 2002 fall component meetings last month in Washington, D.C.

Appelbaum took advantage of the plenary session to apprise APA leaders of important changes within the organization.



Paul Appelbaum, M.D.: "We can change the ways that people think about mental illness and change the policies in this country at both the federal and state levels."

New Structure, New Leadership

One of the changes involved the fall component meetings themselves—this year's attendees were part of a reorganized component structure that involved the reorganization of some components and the sunsetting of others *(Psychiatric News*, April 19).

Appelbaum said that APA's Assembly structure may undergo changes as well. "In keeping with the needs of the times, we are willing to revamp, modernize, and equip APA to deal with the future," Appelbaum said.

Even the structure of APA's Board of Trustees is likely to change, Appelbaum noted. He said that at the Board meeting that concluded just prior to the plenary session, Trustees had voted to eliminate one of the two vice-president positions and combine the secretary and treasurer positions (see page 6). The Board referred the policy to the Bylaws Committee to draft the necessary amendments and report back to the Board.

Also that morning, Trustees had taken the final steps to approve the appointment of the psychiatrist they had selected at their June meeting to become APA's next medical director—James Scully, M.D. (see page 1).

Scully, who is the Alexander G. Donald Professor and chair of the department of neuropsychiatry and behavioral science at the University of South Carolina School of Medicine, will become APA's medical director on January 1, 2003.

When Scully took the podium amid a standing ovation, he promised to devote his efforts to building upon the accomplishments made by APA over the past years.

"I'll need your help as we work together to help APA continue to be a great organization," Scully said. "You take care of the patients of America, and we will take care of you."

What Does APA Do for You?

When Appelbaum is asked "Why should I be an APA member?" or "What can APA do for me?," he is ready with an answer.

"You all know that there is a parity bill now in play on Capitol Hill," he said. Although the House and Senate have both supported different versions of the bill, and President George W. Bush has endorsed parity, "things seems stuck where they are."

Appelbaum said that to move the bill in a positive direction, APA's leaders and staff had set out to reverse the editorial position of the *Washington Post* on mental health parity—and succeeded.

On September 3 he joined APA Medical Director Steve Mirin, M.D., and Executive Director of the American Psychiatric Institute on Research and Education Darrel Regier, M.D., Ph.D., for a crucial meeting with the *Post*. Expectations on APA's side were low, Appelbaum noted.

"The hometown paper of every member of Congress" has twice in the last five years editorialized against mental health parity, Appelbaum noted. However, APA leaders were ready to present their case after being briefed by Laurie Oseran, director of APA's Division of Communications and Marketing, and prepared by staff of APA's Division of Government Relations in a "mock grilling" on the questions they were expected to encounter in the newspaper's headquarters.

Anticipating that they might meet with just one of the editorial staff members, they were pleasantly surprised when six walked into the room, along with one of the *Post's* mental health reporters with whom APA staff had worked before. The meeting was scheduled to last for an hour but stretched into an hour and a half.

"We had a no-holds-barred discussion in which *Post* staff asked questions such as 'How do you diagnose mental illness?,' 'How do you tell if it's real?,' and 'Do you have a science base like the rest of medicine does?' "

The editorial staff expressed concern about the cost of parity—this had been the newspaper's primary reason for opposing parity in the past.

APA staff told them that according to the Congressional Budget Office, parity as proposed in two bills now before Congress would increase annual health insurance costs

please see ***APA's Future*** *on page 13*

Equity for Mental Illness

The following editorial appeared in the *Washington Post* on Monday, September 9.

Last spring President Bush announced a new commitment to improving mental health care for Americans. He cited unfair limits on treatment as one major obstacle to effective care and pledged to seek legislation by year's end to require that insurance plans treat mental illnesses in the same way they treat other medical ailments. Now time is getting short and the calendar is crowded, but Congress still should approve a parity bill, and Mr. Bush, recalling his pledge, should help make it happen.

This isn't the position we took when we last examined the subject, last year, and many of the issues that troubled us then haven't disappeared. Parity legislation is not a panacea. It won't help the uninsured. There's a risk that, by raising costs, it could cause some employers to weaken or abandon existing coverage or charge employees more for benefits. Congress tends to be much more interested in providing benefits than in dealing with their costs: That's especially true for a mandate like this, in which the costs would be borne almost entirely by the private sector. Businesses wrestling with double-digit increases in health care costs are fighting any move that would add even marginally to the problem.

But two factors now seem to us to outweigh those concerns. The first is practical: Experience in both the federal employees' insurance system and in states that have enacted their own parity laws argues that, by managing care, insurers can move toward equal treatment without crippling cost increases. The Congressional Budget Office has estimated that enacting the parity bill now pending in Congress would add just less than one percent to the overall national cost of insurance premiums, though specific costs will vary from business to business depending on what benefits are offered. Insurers, CBO noted this spring, still will be able to exercise the management tools that have been used in the past to decide what treatments are appropriate and warranted, and to hold down expenses. The right response to the gathering health care crisis is to fix the system, not make the mentally ill bear a disproportionate burden.

The second factor is one of fundamental fairness, and of removing the stigma that for too long has shrouded mental illness. Many mental disorders can be clearly diagnosed and effectively treated; some can't. The same can be said of cancers. The pending legislation would require large employers who offer coverage for mental and other illness to handle all disorders in essentially the same way: You can't put treatment limits or financial requirements on mental health benefits that are not imposed on physical ailments. Insurers would not have to pay for what is not medically effective. It's not a huge step, but it would help some people get the treatment they need. It's right to level the field.

Former APA President Dies

Jerry Wiener, M.D., a child and adolescent psychiatrist who led APA and other psychiatric organizations for nearly two decades, dies at age 69.

BY KEN HAUSMAN

Jerry M. Wiener, M.D., who was president of APA for the 1994-95 term, died in Washington, D.C., on September 7 at age 69 after a heart attack.

Wiener was a leader in the field of child psychiatry and served as president of the American Academy of Child and Adolescent Psychiatry from 1987 to 1989. In the 1970s he chaired the psychiatry department at Children's Hospital in Washington, D.C. He also headed the department of psychiatry and behavioral sciences at George Washington University (GWU) School of Medicine for 20 years until he retired in 1997 with the title professor emeritus.

During his two decades as chair of psychiatry at GWU, "Jerry was highly committed to and invested in the personal and professional growth of medical students, residents, and his junior faculty," commented Jeffrey Akman, M.D., who succeeded Wiener as chair of that department. "Whether as faculty advisor, supervisor, teacher, or therapist, Jerry's door was always open to medical students and residents."

In the early 1980s Wiener served as president of the Association of Chairmen of Departments of Psychiatry.

Wiener wrote extensively about psychiatric disorders in children and adolescents and was editor in chief of *The Textbook of Child and Adolescent Psychiatry*.

Wiener served APA in several capacities over his career. He was chair of the American Psychiatric Press Inc. Board of Directors from 1994 to 2000. He also was a member of the Council on Children, Adolescents, and Their Families and served on the Joint Commission on Government Relations. Most recently, he was appointed to the search committee that identified candidates to be the new APA medical director.

In 2000 APA presented him with its Agnes Purcell McGavin Award for distinguished achievement in child and adolescent psychiatry.

"Jerry Wiener shone as a person whose dedication to principle was unwavering," Akman said. He was "uncompromisingly persistent in pursuing what was right."

Wiener is survived by his wife, four sons, and two brothers. ■

WYETH EFEXOR
P4C

DB, Minority Leaders Report From the Field

District branch presidents struggle with declining membership and economic constraints, but are pleased with steps APA has taken to strengthen its partnership with those branches.

Communication between the district branches and APA's central office has improved considerably over the last year, but district branches continue to search for ways to stem the hemorrhaging of their membership rosters. That was the message two district branch presidents conveyed to APA's Board of Trustees at its meeting last month in Washington, D.C.

In keeping with its tradition of inviting two or three district branch leaders and the chair of a committee representing minority and underrepresented psychiatrists, the Board invited David Markowitz, M.D., president of the Psychiatric Society of Virginia; Dina Sokal, M.D., president of the Maryland Psychiatric Society; and Ana Campo, M.D., chair of the Committee of Hispanic Psychiatrists, to discuss issues with which they and the psychiatrists they represent are grappling.

Markowitz noted that the steps that APA has taken to improve its communication with district branches over membership and dues billings are paying off, and Sokal said that her organization is also pleased with the enhancements.

Dina Sokal, M.D. (right), president of the Maryland Psychiatric Society, tells APA Trustees about the problems her district branch faces in recruiting and retaining members and of plans to reverse the trend. Looking on is Ana Campo, M.D., who addressed the Board as chair of the Committee of Hispanic Psychiatrists.

Markowitz, who addressed the Board via speakerphone, also thanked the Trustees for the funds they provided that allowed the Virginia district branch to hire a lobbyist to focus on state scope-of-practice and parity issues. In addition, he pointed out that the state's psychiatrists and the patients they treat are facing a serious shortage of psychiatric hospital beds and a lack of state funds to help low-income patients buy psychiatric medications. State officials are considering joining the growing roster of states that impose a drug formulary on the Medicaid program, he noted.

Difficulty in recruiting and retaining members is a particularly vexing problem for the district branch, he said. More and more young psychiatrists are choosing to begin their careers in community psychiatry or at Veterans Administration facilities rather than going into private practice, and they "don't feel APA has enough to offer" to justify the dues they would have to pay, Markowitz emphasized.

In Maryland, member recruitment is also a critical issue, Sokal stated. With a troubling loss of about 10 to 12 members each year, the district branch is focusing its efforts on convincing residents of the value of membership and has instituted a mentoring program as part of that outreach. The district branch's CME committee has also succeeded in increasing attendance at educational sessions by planning "more creative meetings," she said.

She noted as well that Maryland psychiatrists are on high alert regarding a possible bill in the state legislature to grant psychologists the right to prescribe psychoactive drugs.

Campo, who also chairs the Assembly Committee of Representatives of Minority/Underrepresented Groups, told the Trustees that she appreciates that minority/underrepresented psychiatrists have been included in the recently revamped APA component structure, but that she would like to see a mandate ensuring that every component has one of these representatives. This is the best way "to make sure that ideas and concerns of minority psychiatrists are heard," Campo said.

She pointed out that key concerns of minority psychiatrists are the difficulty they experience when trying to advance in academic and research careers and gain membership on managed care provider panels. ■

BMS CORP
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Residents: Another Program Joins APA's 100% Club

The University of South Carolina School of Medicine is the second institution to have all of its psychiatry residents become members of APA.

They join the ranks of an exclusive organization within APA: the 100% Club. This club was established to encourage residents throughout the United States and Canada to join APA and to do so with other trainees in their programs, according to Deborah Hales, M.D., director of APA's Division of Education, Minority, and National Programs.

The first 10 training programs whose residents all become APA members can submit a photo of their program members—residents, training directors, and department chair—and the photo will be turned into a poster to be mailed to every medical school in the U.S. and Canada to encourage medical students to join APA (see photo). These residents will also be given a 25 percent discount on national membership dues after their first year of membership.

(The first year of membership at the national level of APA is free for residents and $80 thereafter for U.S. residents and $50 for Canadian residents. Membership for medical students is free.)

More information about the program is available from Nancy Delanoche at (202) 682-6126. Programs that are interested in signing up all their residents should also contact Delanoche. ■

LARGE PHOTO, back row, from left: Ronald Prier, M.D., Vashaun Williams, M.D., Ish Major, M.D., Joseph Markowitz, M.D., Trey Causey, M.D., Eric Williams, M.D., Danny Meadows, M.D., Gregg Dwyer, M.D., Rupert McCormac, M.D., Travis Bruce, M.D., and Steve Young, M.D. Front row, from left: James Lee, M.D., Mary Boyd, M.D., Leslie Frinks, M.D., Donna Smith, M.D., Angela Harper, M.D., Jennifer Heath, M.D., Melanie Lobel, M.D., Elizabeth Sikes, M.D., Lisa Sloat, M.D., Nioaka Campbell, M.D., Ayanna Swinton, M.D., Brannon Weeks, M.D., Amishi Shah, M.D., and Robert Ornelas, M.D. SMALL PHOTO, back row, from left: Cassandra Goins Simms, M.D., Claire Hyde, M.D., Margaret Shugart, M.D., Lori Thompson, M.D., Phyllis Bryant-Mobley, M.D., and Niveditha Meghadri, M.D. Front row, from left: Eric Winter, M.D., Samy Tawfik, M.D., and John Bragg, M.D.

Submissions Invited

APA invites submissions for the 2003 American Psychiatric Association Award for Research in Psychiatry. This is the most significant award that APA gives for research. It is given in recognition of a single significant contribution, a body of work, or a lifetime contribution that has had a major impact on the field and/or altered the practice of psychiatry. The award is intended to cover the full spectrum of psychiatric research.

Candidates must be citizens of the United States or Canada and be nominated by a sponsor. Sponsors, who must be APA members, must submit a letter justifying the nomination and summarizing the research accomplishments of nominees in a specific area or with a coherent theme.

Nominees should submit a book, paper, or group of representative and thematically linked books and papers published in English (or accepted for publication); a summary statement emphasizing the principal theme running through the work, its internal cohesiveness and consistency, and scientific implications; an up-to-date curriculum vitae; and an up-to-date bibliography.

All entries must be submitted in seven complete collated sets by November 19 to Alan F. Schatzberg, M.D., Chair, APA Award for Research Board, c/o APA Office of Research, 1400 K Street, N.W., Washington, D.C. 20005. Entries will be acknowledged but cannot be returned. The award is based on an annual competition, and resubmission is permitted. The award, which carries a $5,000 prize, will be presented at APA's 2003 annual meeting.

More information is available by contacting Harold Goldstein, Ph.D., at (202) 682-6851 or by e-mail at goharold@psych.org. ■

Texas Convention

The Texas Society of Psychiatric Physicians will hold its annual convention and scientific program from November 15 to 17 in Fort Worth on the theme "New Frontiers in Psychiatry."

Further information is available from the Texas Society of Psychiatric Physicians at 401 West 15th Street, Suite 675, Austin, Tex. 78701; (512) 478-0605. ■

APA's Future

continued from page 8

by about 1 percent. Yet this 1 percent increase would translate into a 33 percent to 50 percent increase in available dollars for mental health services.

Regier, who has conducted a great deal of research on the costs and benefits of mental health parity, provided the *Post* staff with evidence to support APA's argument that mental health parity is a winning proposition for all.

No one could have predicted what happened next. On September 9, Appelbaum said, "the *Washington Post*, based on the arguments we presented, announced in writing that it was changing its position on mental health parity" (see box on page 8). "We still have another institution to deal with, and that is the U.S. Congress."

He continued, "I present this to you as an example of what APA can do. We can change the ways that people think about mental illness and change the policies in this country at both the federal and state levels."

New Freedom Initiative

Plenary attendees got a glimpse into the inner workings of a new initiative to evaluate and reform the mental health system when guest speaker Anil Godbole, M.D., a member of the President's New Freedom Commission on Mental Health, took the podium. Godbole is an APA member and chair of the department of psychiatry at the Advocate Illinois Masonic Medical Center.

Last April President Bush addressed a crowd at the University of New Mexico in Albuquerque about the many obstacles to quality care for people with mental illness and announced the appointment of the commission. This group is charged with addressing some of these problems, such as stigma and a fragmented mental health service delivery system, by April 2003.

This was no small task, Godbole admitted. "The charge is very extensive, and the time frame limited," he said, referring to the fact that the commission had a year to assess the entire mental health system at the federal, state, and local levels and make recommendations for improvement.

"We are hoping to achieve system reform," he said.

The commission will ultimately recommend improvements that enable adults with serious mental illnesses and children with serious emotional disturbances to "live, work, learn, and participate fully in their communities," Godbole said.

The bulk of the work has been undertaken by a number of committees focusing on specific areas, such as children and families, homelessness, and evidenced-based practices, of which Godbole is chair.

Godbole said that APA leaders have already contributed to the commission's work, but that there was still a great deal of opportunity for input. APA's leadership, Godbole said, could improve the commission's understanding of mental health services data, evidence-based practice, and quality standards of performance measures, among other topics.

Institute Previewed

Before wrapping up the plenary session, Appelbaum introduced Stephen Goldfinger, M.D., who represented the Scientific Program Committee of the 2002 Institute on Psychiatric Services.

Goldfinger described the institute, which will be held at the Palmer House Hilton Hotel in Chicago from October 9 to 13, as "warm and accessible." He highlighted the value of the meeting for psychiatrists-in-training, who benefit from the clinical focus of the meeting and face-to-face interaction with speakers.

More information about the President's New Freedom Commission on Mental Health can be found on the Web at <www.mentalhealthcommission.gov>. ■

Drug Users Not Finding Their Way to Treatment

A survey shows that about 15.9 million Americans over age 12 used an illegal drug at least once last year, and 3.2 million are believed to have abused or be dependent on an illicit drug. But treatment is available, and recovery within reach, say U.S. government officials.

BY EVE BENDER

Denial may be keeping millions of Americans who are in need of substance abuse treatment from seeking help, according to new findings from the 2001 National Household Survey on Drug Abuse.

From 2000 to 2001, the need for substance abuse treatment among people over age 12 rose significantly, according to the survey. While 4.7 million people, or 2 percent of the U.S. population, needed treatment in 2000, an estimated 6.1 million people, or 2.7 percent, did in 2001.

Of the 5 million people who needed but did not receive treatment for an illicit drug problem in 2001, just 377,000 believed they needed it. (Need was determined from responses to questions involving *DSM* criteria.) That leaves almost 4.6 million people who did not think they had a problem with illicit drugs, according to the survey report.

"The denial gap is one of our biggest treatment problems," said John Walters, director of the White House Office of National Drug Control Policy, in a September press conference in Washington, D.C.

The conference marked the 13th annual observance of National Drug and Alcohol Addiction Recovery Month and the release of the findings from the 2001 National Household Survey. "This is why people cannot seek help alone," he said.

Walters appeared with Secretary of Health and Human Services Tommy Thompson and with Charles Curie, who is the administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA).

SAMHSA has conducted the survey every year since 1971 to capture data on the use of illicit drugs, alcohol, and tobacco from a representative sample of people aged 12 and older.

Last year researchers interviewed almost 70,000 people in their homes as part of the data-collection process.

The trio expressed concern over the survey's marijuana-related findings. Between 2000 and 2001, current marijuana use for people aged 12 and older rose from 4.8 percent (10.7 million) to 5.4 percent (12.2 million). Marijuana users account for over three-quarters of the 15.9 million drug users in the United States. All findings relating to marijuana also include hashish.

In addition, the survey showed that of all illegal drugs, marijuana is the biggest source of dependence—62 percent of the 5.6 million Americans who were dependent on illicit drugs were dependent on marijuana.

"Marijuana is not some harmless chemical toy, but a clear and present danger to the health and well-being of all who use it," said Thompson.

Walters linked the increase in marijuana use over the past year in part to a widening perspective within the American public that marijuana is more or less a benign drug—an attitude the survey also measured. He noted that many baby boomers who saw the propaganda film "Reefer Madness" as college students may continue to feel that there is a great deal of unjustified concern about marijuana.

He noted that in the 1970s the level of THC, the active ingredient in marijuana, rarely topped 1 percent. "On the street today," he said, "you can get hybrids with 15 to 30 percent THC content."

For the first time in the survey's history, the researchers collected data on the prevalence of serious mental illness, which they defined as someone "having a diagnosable mental, behavioral, or emotional disorder and functional impairment that interferes with major life activities."

In 2001 there were an estimated 14.8 million adults aged 18 and older with serious mental illness, representing 7.3 percent of all adults. Of this group, 6.9 million people received mental health treatment in the year prior to the interview.

U.S. Secretary of HHS Tommy Thompson: "It pains me to recite some of these statistics, because they are not numerical abstractions. They are human lives. . . ."

Among adults with serious mental illness in 2001, an estimated 3 million had both serious mental illness and substance abuse or dependence.

About 4.3 million youth aged 12 to 17 received treatment or counseling for emotional or behavioral problems in the prior year. The most common reason for the most recent treatment session was that the youth "felt depressed" (45 percent), followed by "breaking rules or acting out" (22.4 percent), and "thought about or tried suicide" (16.6 percent).

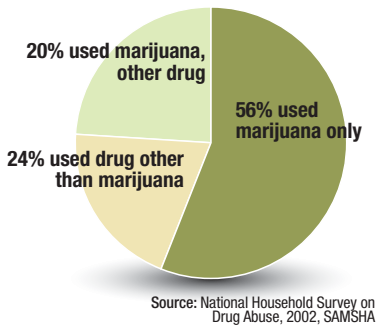
If there was any good news from the survey, it was that smoking initiation rates are

down among young people.

While in 1997 there were 1.1 million new smokers aged 12 to 17, this number dropped to 750,000 in 2000.

Young Rock DiSessa posed quite a contrast to his fellow speakers at the conference. The 20-year-old from Oakland, Calif., delivered the same message as his elders, but in quite a different way. He had once been addicted to drugs and came away from the experience determined to help others in the same situation. He began to drink and smoke at the age of 10, and he rapidly progressed to substance abuse. "Things like family, school, and sports seemed to lose their priority," he said.

Respondents' Marijuana Use



Source: National Household Survey on Drug Abuse, 2002, SAMSHA

At age15, he decided he needed help. "By that time, I'd been kicked out of the house and was living with relatives—my life had crumbled into basically nothing."

He turned to his mother for help, but before they could arrange treatment, the police arrested DiSessa. The teenager wound up on a court-ordered inpatient stay, which led to outpatient treatment. "I am grateful that my family was involved," he said.

It is now four years later, and DiSessa says that his life is full. "I'm attending college, getting good grades, and I've been working for a year and a half—before that, the longest I held a job was 20 days." He said his relationships with others have improved as well. "The things that are important to me are back," he said.

The results of the 2001 National Household Survey on Drug Abuse are posted on the Web at <www.drugabusestatistics.samhsa.gov.> ■

Survey Snapshot

As part of the 2001 National Household Survey on Drug Abuse, conducted by the Substance Abuse and Mental Health Services Administration, researchers interviewed almost 70,000 people to determine prevalence rates of use of illicit drugs, alcohol, and tobacco in the United States. Here are some of the survey's findings:

- Almost half of Americans aged 12 and older—approximately 109 million people—reported being current drinkers of alcohol.
- There are about 10.1 million underage drinkers in the U.S., representing approximately 28.5 percent of Americans aged 12 to 20.
- In 2001 an estimated 8.1 million Americans aged 12 and older tried Ecstasy at least once. This number is significantly higher than the 6.5 million lifetime users in 2000.
- Among young adults aged 18 to 25, the rate of any illicit drug use increased between 2000 and 2001 from 15.9 percent to 18.8 percent.

Groups to Pay for MH Care Of People Impacted by 9/11

To give people directly affected by the attacks of September 11, 2001, an incentive to seek psychiatric care, two charities create a joint, long-term benefit program.

BY CHRISTINE LEHMANN

The American Red Cross of Greater New York and the September 11th Fund in New York City initiated a joint long-term psychiatric benefit program this summer for people directly affected by last September 11.

"We will reimburse the full cost of treatment for eligible people without health insurance or treatment costs not covered by people's health insurance," said Alan Goodman, administrator of the American Red Cross September 11 Recovery Program, told *Psychiatric News*.

Covered services include individual, group, and family counseling, psychotropic medications, psychiatric hospitalization for up to 30 days, and inpatient and outpatient substance abuse treatment, said Goodman.

The American Red Cross plans to spend $40 million on treatment benefits over the next three to five years on this program, said Goodman. The September 11th Fund will spend between $45 million and $55 million over the next five years on treatment benefits and supporting programs that train mental health professionals in the diagnosis and treatment of trauma survivors. Funds will also go to train teachers, clergy, and others to recognize when treatment is necessary, according to Goodman. Each charity has its own eligibility criteria.

The American Red Cross estimated that about 50,000 families fall into its eligibility categories, which include relatives of the deceased or seriously injured in the attacks on the World Trade Center and the Pentagon, rescue and recovery workers, and displaced residents.

The September 11th Fund estimated that about 100,000 people fall into its eligibility categories, which include workers who lost their jobs because of the September 11 attacks, people evacuated from the World Trade Center and nearby buildings, and children attending schools south of Canal Street and their families, Erin Martin, communications director of the September 11th Fund, told *Psychiatric News*.

The charities expect that fewer than half of the eligible people will apply for the long-term benefits.

Maggie Tapp, acting director of mental health and mental health services for the American Red Cross, told *Psychiatric News*, "We have rough estimates of how many people need mental health services based on post–September 11 symptom surveys. But our experience with a similar psychiatric benefit available to eligible families after the 1995 Oklahoma City bombing was that between 15 percent and 40 percent of eligible people used it," said Tapp.

Organizations Collaborate

The charities partnered with the Mental Health Association of New York City (MHA) to screen clients for eligibility for the new benefits and provide referrals to licensed mental health and substance abuse professionals and clinics.

"We offer an easy entry point to treatment through LifeNet, our toll-free counseling hotline, (800) LIFENET, staffed by trained professionals since 1996," said John Draper, Ph.D., a psychologist and director of public education and the LifeNet Network for MHA of New York City.

"If someone is ineligible for the benefits funded by the American Red Cross and the September 11th Fund, they may be eligible for other resources including the federally funded Project Liberty, which provides free, short-term crisis counseling," said Draper.

No Geographic Restrictions

The new benefit program will be publicized along with the LifeNet toll-free number throughout the New York area and nationally by the charities.

Goodman emphasized that the American Red Cross places no geographic restrictions on benefit eligibility. "Relatives of the deceased can call LifeNet to access benefits from anywhere in the world."

"Because this is a program based on financial need, we want people who have health insurance to use [their insurance] first. But if they prefer to see an out-of-network provider, we will reimburse them for the higher copayment," said Goodman.

Draper anticipated that approximately 75 percent of people eligible for the benefit program have some type of health insurance.

The charities have hired American Case Management to process claims, check credentials of mental health and substance abuse professionals, and monitor the quality of care that patients receive, said Goodman.

Draper is seeking to expand the referral network of mental health and substance abuse professionals beyond Manhattan.

He recently contacted state associations representing psychiatrists, psychologists, group psychotherapists, social workers, and marriage and family counselors about participating in the LifeNet Network.

James Nininger, M.D., immediate past president of the New York State Psychiatric Association, told *Psychiatric News* that Draper contacted the state association. "We expressed interest in participating in the treat-

please see ***9/11 Care*** *on page 42*

PBS Viewers to Get Glimpse Of Freud's Early Years

For two hours this fall, television viewers can travel back in time to one particularly well-known couch at 19 Berggasse, Vienna, to witness the genesis of psychoanalytic thought.

BY EVE BENDER

The birth of psychoanalysis was by no means seamless. The foundations of psychoanalytic thought only came about after a series of false starts, painful moments, and striking self-revelation. A new PBS television special will document the long journey of a young Viennese doctor who has forever changed our concept of self.

"Young Doctor Freud," a two-hour special on the birth and growth of psychoanalysis, will air on PBS on Wednesday, November 27, at 9 p.m. Producer and director David Grubin has recreated the story of Sigmund Freud's life, with the aid of Freud's personal letters and writings; commentary from Freud biographer Peter Gay; Freud's granddaughter, Sophie Freud; and several of today's prominent psychoanalysts.

Grubin told *Psychiatric News* that he wanted to create a film about the man who "single-handedly created an entire new field that has profoundly altered the way we think and feel about ourselves. I wanted to understand how he did it—that is what 'Young Doctor Freud' is all about."

The film follows Freud through some of the most important periods of his life. As a student of neuroscience at the University of Vienna in the 1870s, Freud blossomed under the tutelage of Professor Ernst Brücke, from whom he learned that nothing is valid unless it fits into the strict laws of physics and chemistry, Grubin noted.

However, Freud would one day go beyond what he learned in Brücke's laboratory to develop a theory of mind that was not based on the brain.

With the advent of Freud's later theories on wish and fantasies, for instance, he "enters the world of mind and imagination—providing extraordinary material for humanities, literature, and the arts," said Morris Eagle, Ph.D., in the film. Eagle is a professor of clinical psychology at Adelphi University in New York.

In 1885 Freud won a scholarship to medical school to study with Jean Charcot, one of the most famous neurologists of the day. During this scholarship, Freud became obsessed with revealing the hidden roots of hysteria. In his private practice, Freud used hypnosis, as Charcot did, to treat his patients who had hysteria.

"Young Dr. Freud" also chronicles Freud's work with Josef Breuer, a physician who encouraged his patients to speak freely about their pasts while under a hypnotic trance. Ultimately, Freud discovered that the symptoms of hysteria abated only temporarily with this technique. So began the "talking cure."

He likened his work to an archeology of sorts when he described analysis as "excavating a buried city; clearing away the pathogenic and psychical material, layer by layer."

The film depicts how much of the substance behind Freud's burgeoning theories came from sometimes painful self-revelations that occurred in tandem with the treatment of his patients. Grubin reserves the latter part of his film to delve into Freud's childhood, since it is only as an older man that Freud gleaned new insight into the youthful experiences that would shape him as an adult.

The analyses of his own dreams and memories from childhood led Freud in bold new directions—while sexuality was seldom discussed in Viennese society, it became a focus of Freud's theories.

The Viennese Society of Psychiatry and Neurology rejected his claims that hysteria may have been caused by the "grave sexual injuries" inflicted upon children by adults.

"At that time, I'd reached the peak of loneliness. No one paid any attention to me, and the only thing that kept me going was a bit of defiance," Freud wrote of that period of his life.

It would be 20 years before Freud received the acceptance he long sought.

Today, Freud's "insights into the ways our mind is divided and the ways in which we are at war with ourselves change our very conception of human nature," Eagle said. ■

Sigmund Freud is photographed with his mother, Amalia, when he was a teenager.

Health Insurance Premiums Soar, But MH Benefits Hold Steady

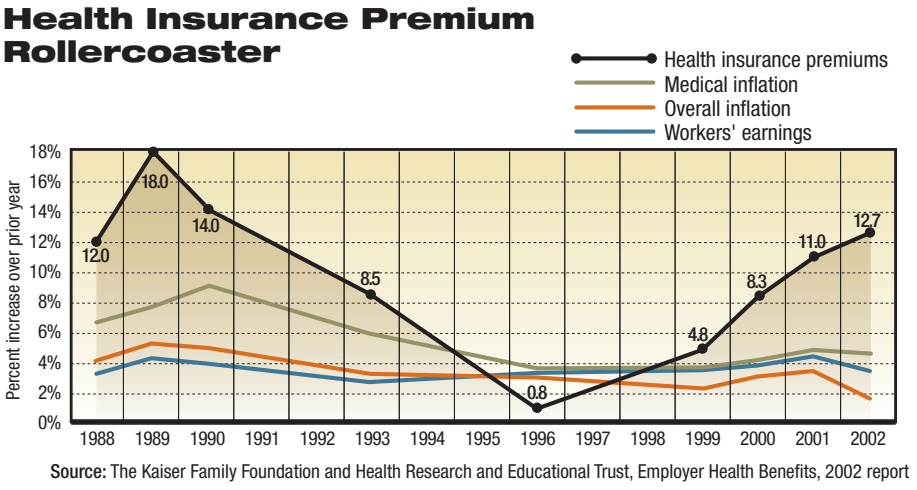
The pattern is clear, according to a major survey of employers. Health insurance premiums are rising, benefits are eroding—and next year will be even worse.

BY KATE MULLIGAN

"When employers say they are going to do something, you can usually count on it," Drew Altman, president of the Kaiser Family Foundation (KFF), told attendees at a Washington, D.C., press conference last month to announce the results of the annual KFF-Health Research and Educational Trust (HRET) survey of job-based health benefits.

Unfortunately, that observation proved true.

In the 2001 Employer Health Benefits Survey, 44 percent of large firms (200 or more workers) said that they were "very" or "somewhat" likely to increase employee premiums in the next year *(Psychiatric News*, October 19, 2001).



Source: The Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, 2002 report

Health insurance premiums have greatly fluctuated since the 1980s and in recent years have dramatically outpaced medical inflation, general inflation, and workers' earnings.

Results of the 2002 survey show that 56 percent of large firms actually did increase those costs. And the future appears even more bleak. Seventy-eight percent of large firms said that they are very or somewhat likely to increase employee premium costs next year.

In the past, explained Jon R. Gabel, HRET's vice president, employers had absorbed much of the cost of premium increases because of the tight labor market and good economic conditions. Now, they no longer feel the need to compete for employees and are passing increased health care costs along to their employees.

Premiums Increased Substantially

For single coverage, employees now pay an average of $454 a year, amounting to a 27 percent, or $95, increase over last year's cost. Employees' share of premiums for family coverage averaged $2,084 a year, amounting to a 16 percent, or $238, increase over last year's cost.

The total average premium cost, which is shared by employers and employees, rose 12.7 percent, the highest increase since 1990. Premiums are now, on average, $3,060 for single coverage and $7,954 for family coverage.

Gabel said, "One of the most alarming findings is the continued growth of underlying health care expenses, which indicates that we can expect double-digit inflation for the foreseeable future. Three more years of this type of inflation could bring family coverage to nearly $11,000."

The survey report contains data showing trend lines for health insurance premiums, medical inflation, overall inflation, and workers' earnings from 1998 to 2002 (see chart above).

Since 1996, when health insurance premiums increased by only .8 percent, premiums have shown the most dramatic rise of the trend lines identified.

Mental Health Benefits Stagnate

Coverage for mental health benefits showed a slight decline. In the 2001 survey, 24 percent of employers reported that employees given mental health benefits had coverage for 20 visits or fewer. In the 2002 survey, that percentage had grown to 32 percent.

Other categories of coverage, for example, 21 to 30 visits, did not change or changed only by 1 percent or 2 percent. "Don't know" declined from 22 percent in 2001 to 14 percent in 2002 (see chart on page 44).

Coverage for inpatient days did not change consistently or dramatically. The percentage of covered workers with 10 days or fewer of coverage for inpatient mental

please see ***Insurance Premiums*** *on page 42*

APA's Campaign Guidelines Emphasize Dignity, Courtesy, and Fairness

Association News

With the announcement of the Nominating Committee's selection of candidates for the 2003 election, the campaign season is officially under way, and members, particularly those wishing to support a candidate, will want to be familiar with the campaign guidelines.

The APA Elections Committee is charged with establishing procedures, with the approval of the Board of Trustees, for equitable voting of the membership. These procedures are documented in the election guidelines section of the *Operations Manual.*

Guidelines prescribing members' election-related activities were established by the Board in the early 1970s, when APA began having contested elections. Restrictions on campaigning were initially adopted as an attempt to address at least four major concerns: (1) to guard against massive campaign efforts "buying" an election win, particularly if those efforts were financed by resources from outside the membership; (2) the revulsion against campaign committees, war chests, and unwelcome bids for public support; (3) the growing distress of the membership at being deluged with campaign materials; and (4) a feeling held by an unknown proportion of the membership that large-scale campaigning was unseemly and inconsistent with their conception of APA's professional image. The concerns are as valid today as they were in the '70s, and the guidelines continue to address them.

There are three sections to the guidelines: guidelines for the candidates and supporters; guidelines for those holding appointed or elected positions in APA/Area Councils/district branches; and guidelines for the use of electronic media.

The intent of the guidelines is "to encourage fair and open campaigning by APA members on a level playing field; foster opportunities for candidates to educate their colleagues about the issues and about their experiences and views; keep costs down; and maintain dignified and courteous conduct appropriate to the image of a profession." Challenges to candidates' records are permitted, but not to their character or institution.

Of utmost importance is the stipulation that candidates and their supporters must use their own resources for election activities (A.1 below). The limits on the number of letters that each person may write were established because the committee believes that 400 letters (or 100 for Area office) is a manageable number for any member wishing to support a candidate (A.2 below).

With the increased use of e-mail, the guidelines for use of electronic media should be noted carefully. While there are no limits on the number of campaign messages that may be sent by e-mail (A.3, first paragraph below), members wishing to support candidates in this way must include the words "APA Campaigning" in the subject line.

Further, the only APA-supported list serve that may be used for campaigning is Member-to-Member (A.3, second paragraph). List serves of other psychiatric organizations may be used for campaigning only if permitted by those organizations. These changes were recommended by the Elections Committee based on APA members' responses to the campaign guidelines poll conducted by the Ad Hoc Committee to Review Election Policies and Procedures in September 2000 *(Psychiatric News*, November 17, 2000).

APA's Web site will once again contain information about candidates, with links to the homepages of candidates who have Web sites.

The Elections Committee recognizes that there have been problems (and always will be) in implementing the guidelines and in creating guidelines that are inherently equitable, given the diversity of APA's membership and candidates. However, the majority of members responding to the campaign guidelines poll indicated their satisfaction with the current guidelines. Members and candidates alike believe that the guidelines have achieved the objectives for which they were designed.

The Elections Committee encourages members to get involved in the election process, to support the candidates of their choice, and to encourage others to do so by writing personal letters to friends and colleagues or by personal contact. The committee is open to any suggestions the membership has to improve or change the guidelines. Most importantly, we encourage you to vote and to urge your colleagues to do the same. Ballots will be mailed January 6, 2003. Election information will be included in the December 6 issue of *Psychiatric News.* ■

This article was prepared by APA's Elections Committee.

APA Campaign Guidelines

A. Guidelines for APA Candidates and Supporters

The intent of the guidelines is to encourage fair and open campaigning by APA members on a level playing field; foster opportunities for candidates to educate their colleagues about the issues and about their experiences and views; keep costs down; and maintain dignified and courteous conduct appropriate to the image of a profession. Candidates' records may be challenged but not their character or institution.

Campaigning (written or e-mail solicitation of votes or support) is permitted only after Nominating Committee nominations are reported to the Board of Trustees. Members circulating petitions may not use the petition process for campaign/electioneering purposes beyond asking for signatures on petitions.

1. Money/resources: Candidates/supporters must use their own resources for election activities. Fund raising is not permitted, nor is sharing of materials, such as letters, postcards, stamps (with the exception of mailing address labels or disks of mailing address labels). Candidates/supporters may not organize campaign committees and candidates may not enter into agreements to campaign together.

2. Letters: Election "letters" include letters, postcards, and faxes, asking for a member's election support. Follow-up mailings of a c.v., fact sheet, bio are permitted and are not included in the letter limits. Handouts may be made available at meetings attended by the candidate.

- Each candidate/supporter generates his/her own "letters" with his/her own personal resources; no APA/Area/district branch resources may be used.
- Each candidate/supporter may write up to 400 letters for candidates for national office or 100 for candidates for Area trustee.
- Mailing address labels or disks of mailing address labels may be purchased from APA/Area Councils/district branches and may be shared.
- Third-party endorsements are not allowed.
- Duplicated material may accompany each letter as a single attachment, but not multiple copies of attachments intended for further distribution.
- Candidates are encouraged to send a copy of these guidelines to members they ask for support.

3. E-mail: E-mail used for campaign purposes must comply with the intent of the guidelines with regard to content and must contain the words "APA Campaigning" in the subject line. There are no limits on the number of campaign messages sent by e-mail. Obtaining e-mail addresses is the responsibility of the candidates and their supporters; such addresses may not be as readily available as mailing addresses. See also Section C.

APA list serves created for conducting business of an APA component or list serves using APA technology (except Member-to-Member) may not be used for campaigning. List serves of other psychiatric organizations may be used for campaigning if permitted by those organizations. See also Section A.5 below.

4. Presentations: Candidates may attend no more than four mutual presentations with their opponent(s). If all candidates have been given equal opportunity to attend and one cannot attend, the other candidate(s) may present but must count the presentation as one of eight made in his/her professional capacity (see below). The annual presentations at the Institute on Psychiatric Services and at the Assembly count as two of four mutual presentations by candidates for president-elect. In addition, grand rounds, lectures, presentations at APA meetings, and other kinds of presentations made in one's professional capacity should be limited to no more than eight during the campaign period. "Presentations" are those made to an audience with a significant number of psychiatrists, academic/psychiatric gatherings such as grand rounds, hospital lectures, etc. Running for office should not inhibit or prohibit candidates from conducting their usual professional business; every effort should be made to define "usual professional business" in the narrowest sense.

5. APA members in other organizations: All APA members are expected to abide by the APA election guidelines in APA elections, including in their capacity as officers and members of other organizations. APA requests that other organizations adhere to the intent of the campaign guidelines and provide fair and equitable coverage of opposing candidates.

6. Compliance: Each candidate receives a copy of these guidelines and a statement to sign, certifying that he/she has read the guidelines; promises to abide by them; will immediately report any deviations of which he/she becomes aware to the Elections Committee; and will notify and try to correct any supporter upon learning of an actual or potential deviation. The Elections Committee investigates any potential violation of which it becomes aware, and reports violations to the Board of Trustees. The procedures used by the Elections Committee to investigate and report campaign violations are in Chapter 2 of the *Operations Manual* and will be sent to candidates with these election guidelines.

B. Guidelines for Those Holding Appointed or Elected Positions in APA/Area Councils/District Branches

1. Money/resources: APA/Area/district branch funds or services cannot be used to endorse, support, or promote any candidate; however, district branch or Area funds may be used to support the expenses of candidates invited to the branch/Area meeting for election purposes (see #3 below). APA/Area/district branch or APA organizational stationery cannot be used. Candidates/supporters who hold appointed or elected APA/Area/DB positions may refer to their titles in the body of the letter, but if they choose to sign the letter, they may not do so over their APA organizational title. Likewise, e-mails should not be "signed" using an APA organizational title.

2. Newsletters: District branch or Area newsletters may announce as news items of up to 150 words per candidate the candidacy for national office or Area trustee of member(s) of that district branch/Area, with pictures. Editorial endorsement of candidates is prohibited, as are letters to the editor in support of or opposition to candidates. Newsletters may print statements or other materials by or about a candidate only if they give equal opportunity to opposing candidates. Newsletters cannot be distributed beyond the usual newsletter distribution.

3. Meetings: Candidates invited to attend district branch meetings to campaign may do so only if their opponent is also invited to the same meeting. Candidates invited to make scientific presentations at district branch meetings may not discuss election issues unless their opponents have been given an equal opportunity to do so.

C. Guidelines for Use of Electronic Media

Candidates and their supporters using electronic media for campaign purposes are expected to comply with the guidelines set forth in Section A and Section C.

1**. APA's Web site:** APA will include information on all candidates (the photos, biographies, and statements printed in *Psychiatric News)* and on the election itself (campaign guidelines, ballot mailing and return dates, etc.) on its Web site. This election information can be accessed through the election logo and linked to other information as appropriate.

2. Candidates' homepages: APA will provide links from its Web site to the individual homepages of the candidates. Each candidate is responsible for setting up and financing his/her own homepage. There will be a disclaimer on APA's Web site stating that candidates' homepages are their own creation and responsibility, and that APA takes no responsibility for information posted on them. APA reserves the right to cut the link between its Web site and a candidate's homepage if a candidate violates the campaign guidelines. No other individual, institutional, or organizational homepages will be used for campaigning.

Interpersonal Psychotherapy Found Effective for Eating Disorder

Learning to seek companionship in people rather than food may be as effective a strategy as monitoring how much one eats in the war against binge-eating disorder, suggests a study comparing two forms of psychotherapy.

BY JOAN AREHART-TREICHEL

Cognitive-behavioral therapy (CBT) is no sure-fire cure for binge-eating disorder. Yet until now no other psychotherapy has been shown to be as effective against the disorder. CBT consists of strategies to help binge eaters normalize their eating habits. For instance, writing down foods eaten, times eating occurred, and the eating context helps binge eaters identify times and situations in which binge eating is more likely to occur and often makes it clear to them how chaotically they've been eating. The therapy also includes strategies to help binge eaters realize that, even if they are overweight, people are still going to like them.

Now interpersonal psychotherapy has been found to be as effective for binge-eating disorder as is cognitive-behavioral therapy in a study headed by Denise Wilfley, Ph.D., an associate professor of psychiatry and psychology at Washington University School of Medicine, and coworkers. They report their findings in the August *Archives of General Psychiatry*.

Interpersonal Problems

Interpersonal psychotherapy for binge-eating disorder helps people identify interpersonal problems that may predispose them to compulsive overeating and learn how to correct those difficulties. For instance, people with the disorder may lack the skills to make friends, so they turn to food when lonely. They may turn to the same solution after fighting with a partner, in which food provides some solace.

In 1993 Wilfley and coworkers reported evidence suggesting that interpersonal psychotherapy might be just as good a treatment for binge-eating disorder as cognitive-behavioral therapy. Because the study was based on a modest sample (56 participants), however, they decided to again pit interpersonal therapy against cognitive-behavioral therapy in treating the disorder, but this time using 162 subjects.

The subjects were randomly assigned to 20 weekly sessions of either cognitive-behavioral therapy or interpersonal psychotherapy. Although the sessions were group sessions, each participant also received individual sessions before, in the middle, and at the end of treatment to individualize the intervention for each participant.

Subjects' binge-eating habits and weight were assessed before treatment, after the weekly treatment sessions ended, and at four-month intervals up to a year after treatment.

Binge-eating recovery rates, the researchers found, were comparable for both treatment groups immediately after treatment ended (79 percent for cognitive-behavioral therapy and 73 percent for interpersonal psychotherapy). Binge-eating recovery rates were also similar for both treatment groups one year after treatment had ended (59 percent for cognitive-behavioral therapy and 62 percent for interpersonal psychotherapy).

True, persons with binge-eating disorder often struggle with being overweight as well as with binge eating, and all of the 162 subjects in this study were overweight. Neither type of therapy led to a dramatic reduction in weight in a number of subjects. Specifically, there was a statistically significant average decrease in body-mass index for participants in both groups from baseline to the one-year follow-up, but the decrease was not enough to reduce the health risks associated with being considerably overweight.

Nonetheless, some individuals in each treatment group did manage to lose enough weight to benefit their health. These were the subjects who had abstained from binge eating at the end of treatment until the one-year follow-up.

Focus Away From Food

The finding that interpersonal psychotherapy is just as good as cognitive-behavioral therapy in halting binge eating and overconsumption should prove heartening to those who engage in both behaviors, one of the study's co-authors, Brian Saelens, Ph.D., assistant professor of pediatrics at Cincinnati Children's Hospital Medical Center, said. Interpersonal psychotherapy, he explained to *Psychiatric News*, "is a novel approach relative to many of the approaches that individuals with binge-eating disorder have tried before. It takes some of the focus away from food and eating—issues that individuals with binge-eating problems have often struggled with most of their lives."

The study was supported by grants from the National Institute of Mental Health.

The study, "A Randomized Comparison of Group Cognitive-Behavioral Therapy and Group Interpersonal Psychotherapy for the Treatment of Overweight Individuals With Binge-Eating Disorder," is posted on the Web at <http://archpsyc.ama-assn.org/issues/v59n8/rfull/yoa20409.html>. ■

LILLY ZYPREXA
P4C

War Correspondents Suffer Serious MH Fallout

Researchers have completed what may be the first scientific study of how covering a war affects journalists' psyches. The findings are sobering.

BY JOAN AREHART-TREICHEL

Although working as a war correspondent can be extremely dangerous, as the case of *Wall Street Journal* correspondent Daniel Pearl earlier this year attests, and the physical danger in turn places great stress on the psyche, it appears that no research has been done on the psychological health of war reporters.

So Anthony Feinstein, M.D., Ph.D., an associate professor of psychiatry at the University of Toronto, and his coworkers decided to explore that issue, especially as more and more research is being conducted on the psychological impact of war on soldiers and civilians.

The results of their investigation, which appear in the September *American Journal of Psychiatry*, are hardly surprising: War correspondents are at high risk for alcohol abuse, major depression, and posttraumatic stress disorder.

First they approached six major news organizations—CNN, BBC, Reuters, CBC, Associated Press, ITN (Independent Television News), and the Rory Peck Trust (an organization representing freelance journalists)—and explained the purpose of their study. All agreed to participate and provided them with the names, work addresses, and e-mail addresses of 170 war correspondents.

These men and women were among the most experienced and respected correspondents. They had been reporting wars, on average, for 15 years. They had been shot at and wounded. They had survived plane crashes. They had lost close colleagues. They had even had bounties placed on their heads and been subjected to mock executions.

Feinstein and his colleagues then sent a questionnaire to each of these correspondents to obtain information about their alcohol and illicit drug use and past and present psychological states. The questionnaire included the 28-item General Health Questionnaire, which contains four subscales, each with seven questions, describing symptoms of somatic complaints, anxiety, social dysfunction, and depression; the Beck Depression Inventory, which contains 21 mood-related questions; and the Impact of Event Scale—Revised, which consists of 22 questions that closely follow *DSM-IV* criteria for posttraumatic stress disorder.

One journalist was murdered before the questionnaire reached him, thereby reducing the number of potential subjects to 169. Of these, 140 (83 percent) returned completed questionnaires.

Feinstein and his coworkers then approached 134 domestic journalists who were comparable to the war journalists in age, gender, and years of journalistic experience to learn whether they would be willing to serve as controls. One hundred and seven (80 percent) said yes, and each of these journalists filled out the same questionnaire that had been sent to the war journalists.

Then came the second, more challenging phase of the study—personal interviews with 28 (20 percent) of the war journalists. These 28 had been picked randomly, and the interviews took place over a period of several months in cities as far flung as New York, London, Paris, Madrid, Barcelona, and Johannesburg. The interview instrument that was used was the Structured Clinical Interview for Axis I *DSM-IV* Disorders (SCID). It indicated whether the subjects had ever had a major depression or currently had one, and whether they had ever had posttraumatic stress disorder or currently had it.

Nineteen (18 percent) of the domestic journalists were also randomly selected to take a SCID interview, and these interviews were conducted either face to face or by telephone.

Feinstein and his colleagues then analyzed the results from phase one of the study and compared results for the war correspondents with those for the domestic journalists.

One unit of alcohol was defined as a regular-size bottle of beer, a glass of wine, or a shot of spirits.

The average weekly alcohol consumption levels for the war-correspondents group, 15 units for men and 11 for women, was two and three times those of the domestic journalist group, respectively. With 14 units of alcohol per week considered the upper limit of acceptable drinking for men, 45 war correspondents, compared with only 13 domestic journalists, were drinking excessively—a highly significant difference statistically. The war correspondents also had significantly higher scores on the Beck Depression Inventory, and this difference was confirmed by the scores on the General Health Questionnaire's depression subscale. As for PTSD symptoms, such as intrusive thoughts and images of traumatic events, 20 war correspondents (16 percent) had them, whereas only nine (10 percent) of the controls did, also a highly significant difference.

The researchers then analyzed the results from phase two of the study and compared results for the war correspondents with those for the controls. Six of the war group (21 percent) had experienced a major

please see ***Correspondents*** *on facing page*

med check

Psychiatric News **introduces a new feature—a monthly column that reports on regulatory and legal actions, news from the drug industry, and reports from clinicians and researchers involving psychotropic medications. We welcome your feedback at pnews@psych.org.**

COMPILED BY JIM ROSACK

Regulatory Briefs

• As this column was going to press, a federal district judge in Los Angeles was still reconsidering her previous order to GlaxoSmithKline (GSK) to halt TV commercials for its leading antidepressant Paxil (paroxetine). After both the Food and Drug Administration (FDA) and Department of Justice openly criticized her ruling, saying she was overstepping her authority and encroaching upon the sole regulatory authority of the FDA to approve drug advertising, the judge stayed the order, allowing the FDA to submit a brief in the case. The ads in question, say a group suing GSK in this particular case, are misleading because they claim that Paxil is "not habit forming." The case is important legally, both as a challenge to the FDA's authority over drug advertising and in addressing the question of whether discontinuation symptoms associated with Paxil (and other SSRIs) constitute actual withdrawal, indicating that the drug may have addictive potential.

• GSK announced last month that it is asking the FDA to approve a first-ever indication for "the long-term management of bipolar I disorder to delay the relapse/recurrence of depressive episodes" for its antiseizure drug, Lamictal (lamotrigine). In a supplemental new drug application (sNDA), the company supported the new indication with two 18-month studies of nearly 650 adults with bipolar I disorder. In both studies, Lamictal significantly delayed the relapse/recurrence of mood episodes, particularly depressive episodes.

• Forest Laboratories announced that its sNDA on its new antidepressant Lexapro (escitalopram) has been approved by the FDA. The approval adds the indication "for the long-term maintenance treatment of major depressive disorder" to the Lexapro label.

• Bristol-Myers Squibb Co. and codeveloper Otsuka Pharmaceutical Co. announced the receipt of an approvable letter on the long-awaited "next generation" of schizophrenia medications, aripiprazole. The FDA issued the approvable letter but did not approve the proposed trade name of Abilitat. Analysts suspect the name is too close to Adalat—Bayer Corp.'s brand of the calcium channel blocker nifedipine, which is used for hypertension. Although it appears the Abilitat name will pass European muster, the company and the FDA are looking at the name Abilify.

• Eli Lilly and Co. last month received an approvable letter for its new ADHD drug, Strattera (atomoxetine.) The company said the approval is "contingent on labeling discussions" and more significantly on "submission of additional data or analysis from either existing studies or a potential new study." Lilly still hopes to debut the new drug in spring 2003; however, industry analysts are wondering whether the FDA's unspecified concerns would be satisfied that quickly.

• Pfizer acknowledged last month that it will be delaying its new drug application on pregabalin for generalized anxiety disorder while it conducts additional clinical studies on the drug's safety. The company had hoped to have the drug to the FDA by the end of this year, but now expects to submit the drug to European regulators in spring 2003 and then to the FDA "sometime after that." A spokesperson for Pfizer would not comment on what issues would be addressed in the new trials.

• A new drug application for memantine, Forest Labs' new drug for moderate-to-severe Alzheimer's disease, was filed with the FDA in July, and there are three additional clinical trials in progress, The drug appears to benefit patients' function and cognitive skills significantly when added to existing donepezil therapy. In a company-funded six-month trial of more than 400 patients, 20 mg of memantine added to donepezil provided significant improvements as measured by the ADCS-ADL, SIB and CIBIC-Plus assessment tools, compared with donepezil plus placebo.

Research Briefs

• Lithium has the most published supportive evidence in the treatment of conduct disorder, followed by conventional neuroleptics and atypical neuroleptics, according to a European review of both controlled and open trials of medications to treat young people for conduct disorder. The authors cautioned, however, that evidence in each case is limited.
(*Eur Neuropsychopharm* 2002 12: 361-370.)

• Risperidone appears to be effective and well tolerated to control severe disruptive behaviors like aggression and destructive behavior in children with below-average IQs. In a company-funded study, the atypical antipsychotic was shown to reduce problem behaviors by nearly 50 percent, compared with a 20 percent reduction with placebo.
(*J Am Acad Child Adol Psychiatry* 2002 41:1026-1036.)

• Paroxetine, long thought of as a "simple SSRI," may actually be a dual reuptake inhibitor after all, potentially explaining its wide application in various mood disorders. In a company-funded study, researchers found that paroxetine at common clinical doses decreased norepinephrine reuptake by roughly 30 percent while blocking nearly 75 percent of serotonin reuptake. At higher doses norepinephrine reuptake was blocked by 43 percent. This is one of the first studies to show dual reuptake capability in human subjects taking oral doses. Previous studies had shown the effect in animals.
(*Am J Psychiatry* 2002 159:1702-1710.)

• Citalopram (Forest Labs' Celexa) given intravenously appears to be a safe and effective way to control overwhelming symptoms in treatment-resistant obsessive-compulsive disorder. Nearly 60 percent of patients in the company-funded study showed YBOCS score decreases of greater than 25 percent within 21 days.
(*J Clin Psychiatry* 2002 63: 796-801.)

• Sertraline dosing may need to be adjusted in adolescents, according to a new study from the National Institute of Mental Health. Because the half-life of the drug is dose dependent (half-life increases as dose increases) and is significantly shorter from the first dose to steady state, adolescents may need twice-a-day dosing. The study also suggested that most adolescents will need doses higher than 50mg/day to achieve a therapeutic effect.
(*J Am Acad Child Adol Psychiatry* 2002 41: 1037-1044.) ■

clinical & research news

Correspondents

continued from facing page

depression at some point in their lives, and two of that group (7 percent) currently were experiencing one. In contrast, only one journalist in the control group had ever had a major depression, and it had taken place before he had become a journalist. As for PTSD, eight of the war group (29 percent) had the disorder at some point in their lives, and three (11 percent) currently did. None of the domestic journalists indicated past or current PTSD.

Thus, it appears that war journalists are at high risk for alcohol abuse, major depression, and PTSD, Feinstein and his coworkers concluded. In fact, war journalists' "lifetime prevalence for posttraumatic stress disorder is similar to that reported for combat veterans," they pointed out.

These findings, they declared, should "come as a wake-up call to news organizations that all is not necessarily well with the men and women who, at considerable risk, bring us news of the world's conflicts."

The study was funded by the Freedom Forum and the Guggenheim Foundation.

The study, "A Hazardous Profession: War, Journalists, and Psychopathology," is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/159/9/1570?>. ■

Experts Narrow List Of Violence Risk Factors

Most seriously mentally ill persons in the public mental health system do not commit violence. However, those who do may very well be those who have been victimized by violence, are currently exposed to violence, and abuse substances.

BY JOAN AREHART-TREICHEL

The subject of violence and mental illness is complex and controversial. For instance, the one-year prevalence rate of violence committed by mentally ill people has been estimated to be anywhere between 7 percent and 58 percent, depending on the types of patients studied and the methodology used. And numerous risk factors for violent behavior by mentally ill people have been cited—anger, aggression, impulsiveness, mood disturbance, delusions, hallucinations, substance abuse, and so forth.

Thus, Jeffrey Swanson, Ph.D., an associate professor of psychiatry and behavioral sciences at Duke University Medical Center, Marvin Swartz, M.D., a professor of psychiatry at Duke, and colleagues undertook a study to pinpoint better the prevalence of violence among seriously mentally ill patients being treated in public mental health facilities and to pinpoint risk factors for violent behavior in this particular population.

As they reported in the September *American Journal of Public Health*, the one-year prevalence rate for violence in the particular group they studied was 13 percent, and three major risk factors for violence in this particular population were identified—having been a victim of violence in childhood, being currently exposed to violence, and abusing substances.

Swanson and his team recruited 802 subjects with serious mental illness from the public mental health systems of four states. They came from a state psychiatric hospital and two community mental health centers in New Hampshire, two city mental health centers in Connecticut, two community mental health centers in Maryland, a psychiatric inpatient unit of the Durham, N.C., Veterans Affairs Medical Center, and some other inpatient and outpatient units in North Carolina.

The subjects provided detailed information about any violent behavior in which they had engaged during the previous year—that is, any assault causing bodily injury or use of a lethal weapon to threaten someone. They answered detailed questions about any physical or sexual abuse they had experienced before or after age 16. They provided demographic and social-environmental information, such as age, sex, race, marital status, income, or exposure to violence in their current environment. Subjects' psychiatric diagnoses, use of substances, functional impairment, and whether they were complying with their psychiatric medication regimens were also assessed.

The researchers analyzed the data to determine the one-year prevalence of violent behavior among the subjects. Thirteen percent of the subjects reported having committed violent acts during the previous year.

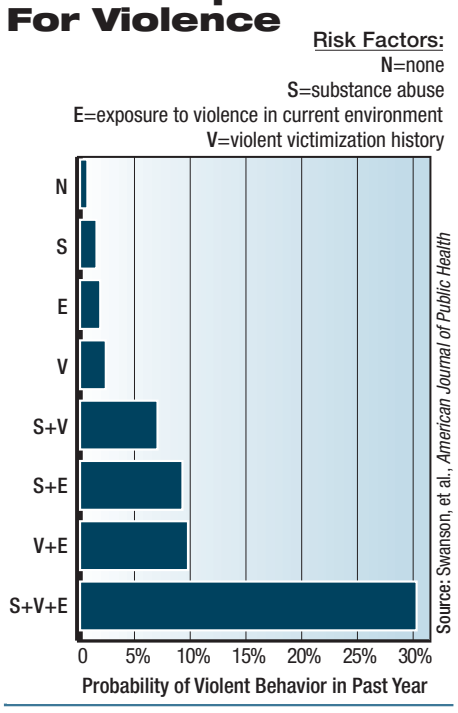
The investigators then assessed their data to determine which demographic, social, environmental, or clinical variables contributed to violent behavior. Homelessness and exposure to community violence were found to be associated with violent behavior to a statistically significant degree. So were substance abuse, self-rated mental health status as "poor," onset of a psychiatric disorder before age 19, psychiatric admission during the past year, and having been victimized by violence.

Finally, the scientists analyzed the data to determine the relative importance of these risk factors for violence. They found that the three most important factors were past victimization by violence, exposure to violence in the current environment, and substance abuse. They also found that the one-year predicted probability of violent behavior in the population they studied was virtually nonexistent if none of these three risk factors was present; that it was about 2 percent if either substance abuse, violent victimization history, or current exposure to violence was present; that it was between 7 percent and 10 percent if two out of the three risk factors were present; and that it was 30 percent if all three risk factors were present.

Psychiatric News asked former APA Pres-

please see ***Violence*** *on page 37*

A Prescription For Violence



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Can Taking Supplements Help Curb Prison Violence?

A British study suggests that vitamin-mineral-essential fatty acid supplements can reduce disciplinary incidents, especially of a violent nature, in prisoners, but an American prison psychiatrist disagrees.

BY JOAN AREHART-TREICHEL

Could something as simple as a vitamin-mineral-essential fatty acid supplement reduce violence among prisoners? A study published in the July *British Journal of Psychiatry* says it can.

However, an American prison psychiatrist who reviewed the study for *Psychiatric News*, questioned the study's results.

Previous research has linked certain nutrients with brain chemistry and also with specific mental states. Also, omega-6 and omega-3 essential fatty acids, which influence levels of the neurotransmitters serotonin and dopamine, have been found to be deficient among violent offenders. Thus, C. Bernard Gesch, a senior research scientist in the Laboratory of Physiology at Oxford University in England, and colleagues hypothesized that certain prisoners might be lacking in certain nutrients and that correcting this deficiency might help counter their antisocial behavior.

They recruited 231 young-adult prisoners aged 18 and over for their study. Half the subjects were randomized to receive one vitamin-mineral supplement and four essential fatty acid supplements daily for an average of four or five months. The others were given placebos. Neither group knew what it was getting. The placebos looked like the supplements—opaque gelatin capsules—but contained vegetable oil instead.

The researchers tracked the number of disciplinary offenses that the subjects committed throughout the study period to determine whether the nutritional supplements had any effect on them. And the supplements indeed had an impact, Gesch and co-workers reported. The number of disciplinary offenses committed by the supplement group at the end of the study was reduced 35 percent compared with the number it had committed by the start of the study—a highly statistically significant difference. In contrast, the placebo-group's number of disciplinary offenses was reduced only 7 percent during the study period, which was not a statistically significant difference. With regard to reduction in violent incidents from the start to the end of the study, the supplement group experienced a 37 percent decrease, which was highly statistically significant. In contrast, the placebo group experienced a 10 percent reduction, which was not statistically significant. When the number of disciplinary infractions of the supplement group at the end of the study was compared with that of the placebo group, there were 26 percent fewer in the former, a statistically significant difference

Gesch and his colleagues concluded that the supplements reduced disciplinary offenses, especially those involving violence, among their subjects to a "remarkable degree," and their results suggest that "the effect of diet on antisocial behavior has been underestimated, and more attention should be paid to offenders' diets."

Did Deficiencies Exist?

J.S. Zil, M.D., J.D., chief forensic psychiatrist of the State of California Department of Corrections, is skeptical of these results. The reason, he told *Psychiatric News*, is that the researchers purportedly tested the effects of correcting nutritional deficiencies in prisoners' diets, yet there was no concrete evidence that the prisoners, who were receiving prison food, had any such deficiencies in the first place. Had the study design been based on parolees or probationers, who may well have had nutrient-deficient diets, then the study might have been worth undertaking, he noted.

In an interview with *Psychiatric News*, Gesch said that he and his colleagues had only tentative evidence that their subjects had any nutritional deficiencies. It came from food diaries the subjects had filled out and suggested that they were consuming less-than-optimal amounts of minerals such as selenium, magnesium, potassium, iodine, and zinc. Vitamin assessments from the food diaries were less reliable than the mineral assessments, and the food diaries did not divulge the levels of essential fatty acids that subjects were getting.

Better Study to Come

Gesch noted, however, that their study is only a first step in exploring a possible link between nutritional deficiencies in prisoners and their infractions. He and his colleagues, along with researchers from Britain's Institute of Psychiatry and Medical Research Council, will attempt to replicate these findings with a better-designed study. For instance, in the next investigation, they will be analyzing subjects' blood levels of specific nutrients to determine whether they are deficient or not.

The study was supported by donations from various foundations to the charity Natural Justice.

An abstract of the study, "Influence of Supplementary Vitamins, Minerals, and Essential Fatty Acids on the Antisocial Behavior of Young Adult Prisoners," is posted on the Web at <http://bjp.rcpsych.org/cgi/content/abstract/181/1/22>. ■

Knowledge Is Power for Relatives Of Alzheimer's Disease Patients

A number of people who have parents with Alzheimer's disease are willing to be tested to find out whether they carry a gene that confers risk for late-onset Alzheimer's. Those who get bad news say they would still choose to take the test.

BY JOAN AREHART-TREICHEL

In fall 2000, Robert Green, M.D., an associate professor of neurology and director of the clinical corps of Boston University's Alzheimer's Disease Center, and his colleagues wanted to answer an important question: Would relatives of persons with Alzheimer's want to be tested for the gene variant that is known to confer risk for late-onset Alzheimer's—that is, the "e4" variant of the APOE (apolipoprotein E) gene?

They contacted 196 adult children of living or deceased Alzheimer's patients through research registries at university health centers in Boston, New York City, and Cleveland to find out. And the answer is a qualified yes, Green and his coworkers reported at the international Alzheimer's conference in Stockholm in July.

Specifically, of the 196 adult children they contacted, 106 (54 percent) agreed to a phone interview; 55 (28 percent) of those interviewed attended an educational session, and 43 (22 percent) indicated that they were willing to have their blood drawn for an Alzheimer's risk gene assessment. Those wanting to find out whether they carried the risk gene tended to be younger and more highly educated than those who did not; otherwise, there were no significant differences between the two groups regarding age, marital status, family history of Alzheimer's, and degree of worrying about developing Alzheimer's.

After Green and his team found that a number of children of Alzheimer's patients were interested in being tested for the Alzheimer's risk gene, they set up what appears to have been the first-ever clinical trial to examine the impact of receiving Alzheimer's genetic-risk information, including Alzheimer's risk gene disclosure. Eighty children of Alzheimer's patients served as trial subjects and were tested for the Alzheimer's risk gene, while 32 other offspring of Alzheimer's patients served as controls and were provided Alzheimer's gene risk assessment on the basis of family history alone.

Green and his colleagues reported at the Stockholm conference that, of the 80 subjects who were tested for the risk gene, 40 were found to have it—which was more or less what they had expected on the basis of the prevalence of the gene in persons from families with Alzheimer's. A few subjects were found to have two copies of the risk gene.

No Regrets

Nonetheless, 95 percent of the 40 subjects who were found to carry the risk gene said that they would choose gene risk assessment if they had to do it over again, which was comparable to what the 40 subjects who did not have the risk gene said.

The psychological effects of learning that one carries an Alzheimer's risk gene are still being analyzed, Green told *Psychiatric News.* But on the surface, those subjects who got the bad news seemed to take it well. In fact, they seemed to be more distressed by other matters in their lives, such as 9/11, than learning that they carried an Alzheimer's risk gene.

Can Alzheimer's Be Prevented?

The study efforts by Green and his colleagues raise another crucial question: If people are found to carry one or two copies of the APOE e4 variant, can they do anything to lessen their chances of developing Alzheimer's? Emerging research results from other quarters suggest that they can.

For instance, Richard Mayeux, M.D., of Columbia University's Taub Institute for Research of Alzheimer's Disease and the Aging Brain, and colleagues reported study results in the August *Archives of Neurology* suggesting that if persons who carry the e4 variant of the APOE gene eat moderately, they may be able to slash their Alzheimer's risk.

Mayeux and his coworkers selected 1,000 elderly persons with Alzheimer's disease for a study. They assessed their daily calorie and fat intake, tracked them for four years to see whether they developed Alzheimer's, and then used their data to determine whether daily calorie-fat intake influenced Alzheimer's risk while taking the possible presence of the APOE e4 gene variant into consideration.

When subjects without the e4 variant were compared, those who were in the top quarter regarding daily calorie-fat intake turned out to be no more susceptible to Alzheimer's than were those who were in the lowest quarter for daily calorie-fat intake. In contrast, when subjects *with* the e4 variant were compared, those in the top quarter of daily calorie-fat intake turned out to be more than twice as likely to develop Alzheimer's as those who were in the bottom quarter of daily calorie-fat intake.

An abstract of the study, "Caloric Intake and the Risk of Alzheimer Disease," is posted on the Web at <http://archneur.ama-assn.org/issues/v59n8/abs/noc20017.html>. ■

New Journal

continued from page 1

the transition for psychiatrists.

For psychiatrists, the change became reality when, in 1994, the American Board of Psychiatry and Neurology (ABPN) stopped granting psychiatrists board certification on a lifetime basis and adopted a policy whereby psychiatrists would need to take a multiple-choice exam every 10 years to maintain board certification.

Although certification is not required for a physician to practice medicine, most hospitals and managed care organizations require that at least a certain percentage of their staff be board certified.

The new policy extends to all psychiatrists certified after October 1994. Psychiatrists certified before that date may choose to participate in the process voluntarily.

"We believe these educational tools will help all psychiatrists keep up with new developments in clinical practice."

ABPN offered the first recertification exam for general psychiatry this past June.

In March 2003 ABPN will offer recertification exams for geriatric, addiction, and forensic psychiatry, and in April another recertification exam will be given in general psychiatry. All psychiatry recertification exams, including one for child and adolescent psychiatry, will be offered in 2004 and annually thereafter.

Maintenance of Certification

With the appointment of the ABMS Task Force on Competence in 1998, the organization began to develop the framework for the Maintenance of Certification (MOC) initiative. The work of the task force members was rooted in the belief that taking a recertification exam every 10 years was an inadequate measure of competency.

The MOC framework consists of a description of the competent physician, the six general competencies required of all physicians, four required components for each board's MOC program, and the statement that all boards will transition their recertification programs to MOC programs.

The ABPN is gradually implementing the ABMS's MOC initiative—one component at a time, according to ABPN Deputy Executive Vice President Thomas Kramer, M.D. The four required components involve the maintenance of professional standing, lifelong learning and self-assessment, periodic cognitive examination, and practice assessment.

Kramer told *Psychiatric News* that the ABPN had previously required that diplomates adhere to two of those components—maintenance of professional standing, or state licensure, and the periodic cognitive examination, or the recertification exam.

However, the remaining two MOC components—practice assessment and lifelong learning and self-assessment—have yet to become a reality for member boards like the ABPN. With regard to lifelong learning and self-assessment, the ABPN is "in the formative stages" of finding a way to ensure that psychiatrists and neurologists develop a self-assessment plan. Such a plan, Kramer said, would require physicians to assess themselves to identify any deficits in knowledge, develop a lifelong learning plan to compensate for those deficits and keep up with new information in the field, and execute the lifelong learning plan.

However, Kramer emphasized that the time when psychiatrists would need to demonstrate such a lifelong learning plan was not imminent and that it would take years before the ABPN would be ready to provide educational materials that would help diplomates assess themselves. "We have formed an MOC committee, which is just beginning to converse with our specialty societies about how they can provide materials for lifelong learning," Kramer said.

"We are anticipating that professional organizations such as APA will petition us to provide some sort of ABPN-sanctioned lifelong learning," he added, "But we have no system in place to certify educational providers yet."

Under the old CME system, psychiatrists had little incentive to venture into unfamiliar areas of psychiatry. Physicians tended to rack up CME credit by sticking with those areas of psychiatry they knew and liked.

"CME is not content driven," Kramer observed. When attending educational meetings, he said, physicians usually attend those sessions related to their major clinical interests. "In fact, if you want a tax-deductible ski vacation, you can go to a session totally unrelated to your area of interest and still receive CME credit."

APA Journal Debuts

In the age of maintenance of certification, psychiatry is no longer a buffet where one can pick and choose one's favorite food items. Psychiatrists will have to demonstrate knowledge in general, and if applicable, subspecialty areas of psychiatry to maintain their board-certified status.

To help psychiatrists stay current with the latest advances in psychiatry and prepare them for the introduction of the MOC initiative by ABPN, APA is coming out with a new educational tool.

FOCUS: The Journal of Lifelong Learning in Psychiatry will make its debut in January. Each quarterly issue will explore a major topic in psychiatry with a diverse selection of articles. Members will find original clinical articles, comprehensive review articles summarizing current research, practice guidelines, and self-assessment exams.

The co-editors of the journal are Deborah Hales, M.D., director of APA's Division of Education, Minority, and National Programs, and Mark Rapaport, M.D., an associate professor of psychiatry and staff physician at the University of California San Diego School of Medicine and San Diego Veterans Affairs Healthcare System. Hales and Rapaport designed the journal to review systematically all the topics that psychiatrists need to know for recertification in a three-year cycle.

The journal will cover topics such as substance abuse, posttraumatic stress disorder, and geriatric psychiatry. The inaugural issue of the peer-reviewed journal will focus on bipolar disorder.

FOCUS also gives members the opportunity to earn as many as 40 CME credits a year by completing the self-assessment exams in each issue and at the end of the year.

A subscription to the journal includes a mailed paper copy as well as Web access. Those who wish to take their self-assessment exams on the Web can do so quickly and easily. Upon completion of the exam, a CME certificate is sent by e-mail. Subscribers can anonymously compare the results of their self-assessment exams with those of their peers either online or on paper.

"From the annual meeting and the *American Journal of Psychiatry* to our new products—the *FOCUS* journal, our new grand-rounds online program, and other electronic CME offerings in the works—we hope to offer a family of practical educational products," Hales told *Psychiatric News*. "We believe these educational tools will help all psychiatrists keep up with new developments in clinical practice."

APA's grand-rounds online program is similar to that held at a hospital. In the online version, however, a fictional case scenario will be sent by e-mail to APA members who subscribe to the program. Those who are interested can discuss the case on an APA list serve.

APA members can purchase a one-year subscription to* FOCUS: The Journal of Lifelong Learning in Psychiatry *for $195 until December 31. After that, the cost is $299. The cost for nonmembers is $399. Those who wish to subscribe or obtain more information should call (800) 368-5777 or visit <www.appi.org>. ■

Scully

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ing, and research for the South Carolina Department of Mental Health and served as interim director of the department from 2000 to 2001. He also previously directed the department's William S. Hall Psychiatric Institute.

While at APA, Scully held clinical appointments at George Washington University School of Medicine, Georgetown University School of Medicine, and the Uniformed Services University of the Health Sciences. Prior to 1992, he held appointments at the University of Colorado School of Medicine in Denver, as well as the Veterans Affairs Medical Center in Denver.

Scully graduated from Tulane University School of Medicine and completed an internship at the National Naval Medical Center in Bethesda, Md. Before going on to complete his residency in psychiatry at the University of Colorado, he served in the U.S. Navy as a submarine medical officer, attaining the rank of lieutenant commander. During that time, he served in Vietnam as member of the elite Navy Seals.

A Sense of Belonging

Scully noted that he faces several significant challenges as he takes the helm of APA at year's end. He is ready to face, he said, budget constraints, declining membership, and stress and tension in the central office connected to the relocation of APA headquarters and to the significant restructuring of the central office and APA components.

"Clearly the challenges are to continue to function and improve our service to the field of psychiatry and to our members in a time of budget constraints that are severe," Scully said. "But I know that we have an extraordinary staff in the central office that is dedicated and talented, so I'm looking forward to working with them to meet these challenges."

APA is a "great organization," Scully said, and his primary goal is to make APA "the premiere medical specialty organization" in the United States.

On APA's declining membership, Scully noted, APA is no different from many other professional societies, perhaps even faring a bit better.

"One aspect that I had hoped to see post–9/11," Scully said, "particularly from the younger—the X—generation was perhaps some reinvestment in pursuing organizational cohesion. It is an interesting generation, in that they are very invested and highly committed, yet they do not tend to join the old-line organizations."

He hopes to change that by reinforcing a basic need that he sees in all psychiatrists. Psychiatrists, he feels, have been marginalized in the medical community for so long that even though they are "full-fledged members of medicine," they are often not perceived as "real doctors."

Part of the benefit of belonging to APA is that the organization offers collegiality, a place to belong, Scully said.

"APA is that place. APA needs to be filling those needs, but we need to know how to do that better," he added.

"We offer our members world-class publications and world-class meetings—the best that there are. But you can get that whether you are a member or not. . . .What you get as a member is that sense of collegiality, of belonging to something bigger than yourself."

Within psychiatry, it is not only patients who feel isolation and stigma, Scully said. "Psychiatrists have been stigmatized also. They have been in medicine; they have been in the media. You know when someone gets a mental illness, they don't choose that illness. But when someone treats mental illness, that represents a conscious choice. And part of that choice is knowing that you are going to have to deal with certain attitudes and stigma. I honor that choice. And APA honors that choice in supporting all psychiatrists."

Challenging Times

Scully will work with the Board of Trustees, Assembly, and staff to identify ways to give members better value for their dollar.

"Times are tough," Scully said. "The budget's tight. But in a sense that's always the case because you always want to do more than you have the resources to do."

Thus, Scully plans to work with the Board members in implementing priorities they set in spending and direction. "We'll help inform them of the consequences for various decisions, and we'll carry out those decisions. Now in some areas, we'll still need to grow, even as we cut back in others. In a growing, thriving organization, there's learning to do. It's a living thing, an organic thing—hence the root of the term 'organization'—and therefore highly dynamic. Yes, we need to be more efficient, but above all we must be more effective."

Since he left APA's central office in 1996, Scully said that he has gained "tremendous experience." "I've gained more experience in vital areas, having been challenged with ever-increasing responsibilities," he said. "But I'm not much different than I was—my style is pretty much the same."

APA is also fundamentally the same, he said.

"The challenges, the tasks, they are still the same as they have always been, since 1844," he observed. "Service to the mentally ill, through service to the profession—that is APA's mission. We champion our patients through our members."

That service, while fundamentally unchanged, is more complex in today's world, Scully noted, "where you have to do more with less."

Scully said that he is looking forward to working with what he considers an excellent team. "I've been blessed with the people I get to work with," he said. "I was blessed when I was at APA in its education office, I have been blessed with a great group at South Carolina, and I know that it will be true again, returning to APA." ■

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PBW

letters to the editor

Psychologist Prescribing

In the July 5 issue, Dr. Carlos Guzman articulated some salient points against the certification of psychologists for prescribing psychotropic medication. The dilemma is, How can a clinician prescribe a medication without full medical knowledge and training?

Knowing the psychopharmacology alone is insufficient in assessing the mental health of a patient, both medically and neurologically. There are many patients who have multiple medical problems and neuralgic disorders that must be addressed in their evaluation. Many can mimic anxiety and depression.

How will a psychologist assess and treat a 72-year-old woman who presents as depressed and anxious with a change in her personality? To miss the diagnosis of a stroke or delirium or cardiac, endocrinoligic, or infectious problems not only is a disservice to patients and their families, but also could result in the death of a patient.

The sphere of psychiatry has to include a full medical perspective. It is imperative to the lives of our patients and their families.

ERIC GREENMAN, M.D.
Chandler, Ariz.

Evidence-Based Medicine

As someone who has been out of residency just over a year, I find that I completely agree with Dr. Susan Padrino's comments on evidence-based medicine in the August 16 issue. While cookbook medicine removes the human factor from much of the equation, I think in the big picture the advantages to patient care are greater than the disadvantages (and someday the human factor may be understood well enough to factor it into the cookbook).

Aside from writing to thank Dr. Padrino for the article, I wanted to vent some of my own frustration with our developing database of evidence. I know many others are concerned with corporate bias in our practice patterns, but I wanted to point out one more observation from this issue of *Psychiatric News*.

Dr. Padrino's column is on page 13. The large ad on page 11 is for escitalopram (Lexapro). On page 17 is an "article" on escitalopram but without any reference to a peer-reviewed study. Some psychiatrists may even mistake reading that article as "evidence-based medicine" when they choose to prescribe escitalopram. Personally, I know next to nothing about escitalopram (yet), so maybe it is the greatest thing since sliced bread. I'll wait for some peer-reviewed publications.

RICHARD MALIS, M.D.
Riverwoods, Ill.

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.

Editor's note: Dr. Malis makes an excellent point about waiting to reach a judgment on the usefulness of research findings for clinical decisions until more information appears in a peer-reviewed journal. As a newspaper, an important part of Psychiatric News's *mission is to inform readers about medical and scientific developments that could have an impact on diagnosis and treatment. This enables readers to remain up to date on trends in research and clinical practice and to seek out more information on topics of particular interest to them, including information that can help them reach sound clinical decisions.*

clinical & research news

Violence

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ident Paul J. Fink, M.D., to give an opinion about the study report since he has a special interest in the subject of violence and the mentally ill. "I think it is a terrific article," he said. "My understanding was that the mentally ill are much more violent when they have been drinking or using drugs. But I didn't think that abuse, especially abuse that continues through life, was so serious. That's a new finding, I think."

One of the practical implications of these results, the researchers concluded in their report, is that "better-focused and -targeted interventions that assess and anticipate risk of violence [in such a mentally ill population] could reap very worthwhile benefits."

When *Psychiatric News* asked Swartz and Swanson for examples of such interventions, they cited programs that address trauma consequences among the seriously mentally ill and programs that treat both mental illness and substance abuse simultaneously in the seriously mentally ill.

Swartz also commented on the implications of the findings for clinical psychiatrists. "A history of trauma and ongoing substance abuse are important risk factors for violence," he replied. "Both need to be explored in routine history taking. In addition, psychiatrists should inquire about the community environment of the patient and support efforts to find community housing that reduces the risk of exposure to high-crime and high drug-abuse environments."

The study was funded by National Institute of Mental Health grants and a Veterans Affairs Epidemiologic Research and Information Center grant.

An abstract of the study, "The Social-Environmental Context of Violent Behavior in Persons Treated for Severe Mental Illness," is posted on the Web at <www.ajph.org/cGI/content/full/92/9/1523>. ■

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American Psychiatric Press Inc. exhibit at a recent APA annual meeting and, when a new book on the cytochrome P-450 enzyme system caught my eye, I decided it really was time for me to catch up on how competition for the same enzymes by different medications can affect the dosages we should be prescribing for our patients. This was something I'd meant to do for a while, but it's hard to deny that there was something much too contingent about the process. Had I not happened to see the book I needed, I might never have fulfilled my resolution to learn something more about this area.

APA looks forward to playing a major role in helping psychiatrists to rationalize their continuing education and to cope with the new lifelong learning initiative. As an initial step, APA's Division of Education, Minority, and National Programs, in collaboration with the American Psychiatric Press Inc., has designed a new quarterly journal, *FOCUS: The Journal of Lifelong Learning in Psychiatry*. Deborah Hales, M.D., director of APA's Division of Education, Minority, and National Programs, and Mark Rapaport, M.D., are the co-editors (see story on page 1). Beginning in January 2003, FOCUS will cover systematically all the topics that psychiatrists have to know for recertification. These range from bipolar disorder to ethics, from eating disorders to sleep disorders. Over every three-year cycle, FOCUS is designed to provide a complete overview of major topics in psychiatry.

Each issue will contain a comprehensive review article, a shorter "clinical synthesis" article, reprinted "critical articles" from the literature, relevant practice guidelines, and CME (or maybe we should say LLL—for lifelong learning?) questions with five hours of credit for each issue; 20 hours of credit can be earned for the year-end self-assessment test. Continuing education questions can also be answered online, similar to programs that are currently in operation for the *New England Journal of Medicine*, *Pediatrics*, and *Neurology*. This kind of comprehensive, systematic review process will probably need to be part of every psychiatrist's lifelong learning program.

As physicians, we face increased demands for accountability of many kinds. Trainees now need to demonstrate actual competence at performing specific procedures, rather than merely passing pencil-and-paper tests. The medical records we write are sampled to ensure that they are complete and justify the billings we have submitted. We are asked to provide evidence of training in areas for which we are requesting privileges from the hospitals and clinics in which we work. There is no question that many of these new requirements create additional hassles for us. But when done right, they yield considerable benefits as well. The coming focus on lifelong learning offers us an opportunity to rationalize the ongoing education that is an integral part of being a physician. APA is aiming to help make this the best possible experience for psychiatrists. ■

Board

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M.D., as the next APA medical director (see page 1). The Board agreed to a four-year contract and a total compensation package of $425,000 (an annual salary of $375,000, which will increase by 4 percent annually in subsequent years; $30,000 in deferred compensation; and $20,000 in benefits).

• **reduce the annual meeting advance registration fee for international members.** For 2002 the fee had been raised from $185 to $450 to compensate for the fact that international members' dues are $150, much lower than dues paid by U.S. and Canadian members.

A substantial drop in attendance by international members at this year's annual meeting, however, led to a re-evaluation of the fee level, though there was no evidence that the fee was the cause of the decline. The Board agreed to lower next year's registration fee to $350 for international members and to increase nonmember advance registration fees by an as-yet-undetermined amount so that income from these fees ends up being budget neutral. On-site registration will remain the same.

• **defer until the November Board meeting approval of APA's 2003 operating budget.** The Board instructed the Budget and Finance Committee to revisit several substantial program cuts that various Board members thought should be restored. If any of the cuts suggested by the committee are restored, offsetting cuts will have to be identified in other line items so the budget remains in balance. The 2003 operating budget will be approximately $52 million.

• **authorize APA to lease an association management system.** The system will cost about $3.38 million from 2003 to 2008 and is estimated to save APA between $2.4 million and $6.3 million over that period. The system is designed to integrate several now independent databases and internal processes that decrease APA's effectiveness, according to a task force report to the Board, and to result in significant improvements in member and customer services. It will end the duplication of member records by replacing them with one comprehensive record and will allow "a single point of contact for member services."

In addition, the Board was told of several actions taken by the Executive Committee prior to the September meeting. These included

• **approval of a request for funds** from the Texas, Virginia, Florida, and New Mexico district branches. All will use the funds for advocacy at the state level.

• **endorsing proposed guidelines to govern APA's participation in magazine supplements** about mental health issues that are supported by commercial advertising, such as by pharmaceutical companies. ■

APA's Board of Trustees

Traditionally, sitting at the Board of Trustees' table at each meeting are voting and nonvoting members, as well as those specified in APA's *Operations Manual* as "others in attendance." A plan approved by the Board of Trustees at its meeting last month drops one of the vice-president positions and combines the secretary and treasurer positions.

Voting Members of the Board

- Six officers of the Association
  - President
  - President-elect
  - Two vice presidents
  - Secretary
  - Treasurer
- Three immediate past presidents
- Speaker of the Assembly
- Two trustees-at-large
- Early career psychiatrist trustee-at-large
- Member-in-training trustee
- Seven Area trustees

Nonvoting Members

- Past presidents (only those elected prior to 2000), after serving a three-year term as voting members
- Member-in-Training trustee-elect

Others in Attendance

- Speaker-elect of the Assembly
- Chair or representative from Committee of Black Psychiatrists *
- Chair or representative from Committee of Residents and Fellows *
- Representative from APA/GlaxoSmithKline Fellows *
- Representative from APA/CMHS Fellows *
- Representative from APA/Bristol-Myers Squibb Fellows *

*Selected/elected by their own groups.

Troubled Youth

continued from page 2

ural supports, such as relatives, church members, and friends, and assembles a child-family team made up of those people and staff members from child welfare or probation agencies.

The coordinator helps the team to identify necessary services, develops a care plan, arranges for service delivery, and serves as a constant source of support for the child and family.

The program uses a provider network that pays agencies on a fee-for-service basis, allowing coordinators to contract for whatever an individual family needs.

"The money has to follow the family," Chou said.

Chou, however, who is a child psychiatrist, is a salaried employee of Milwaukee County. "It's important that staff members have no profit motive. A salaried position allows us the flexibility to do what's necessary for the patient."

He can see a patient four or five times a week if necessary and take time to visit with families in their homes. In contrast, he does not have to worry about the expense of missed appointments or insist that a child come at the same time each week.

"It's like real life," Chou said. "Change doesn't come about at regularly planned intervals. There are big steps and times when no progress is apparent."

He believes that his medical training is particularly important with this group of patients. "These kids have also been underserved in terms of their other medical needs," he observed.

Demographics suggest the multiple challenges they face. In 1998, 53 percent of the families served were at or below the federal poverty level. Twenty-four percent of the parents had been incarcerated and 22 percent of families had documented mental illness. One in eight of the young program participants had attempted suicide.

"These are families who often have been burned by the system," Chou said. But, he insists, if families believe team members care about their child, they will "come around."

In 2001 data showed that 65 percent of the children at entry had a diagnosis of either conduct disorder or oppositional defiant disorder. Forty-nine percent had a mood disorder, and 46 percent were diagnosed with attention-deficit/hyperactivity disorder.

In 2001, when Wraparound Milwaukee served 869 children and their families, the primary sources of funds were the Bureau of Milwaukee Child Welfare and Delinquency and Court Services. Those sources, which combine federal, state, and local funding, made up 60 percent of the service budget of $24,616,073. Medicaid (31 percent) and Medicaid crisis funds (6 percent) made up the next largest shares.

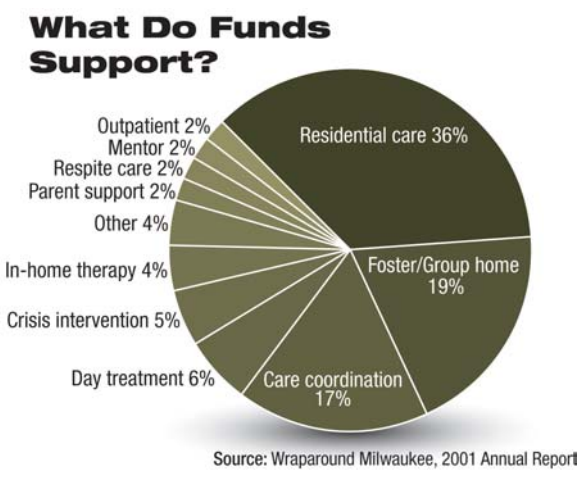
The chart at left shows the percentages of expenditures by type of service.

Although the highest single expenditure was residential treatment, the cost of that service fell every year for the past four years. For 2001, the percentage dropped 8 percent from 2000.

In 2001 the Office of Juvenile Justice Delinquency Prevention featured Wraparound Milwaukee in a national satellite teleconference and film, and CMHS chose it as one of two national host learning communities to assist other federal grantees.

This year the President's New Freedom Commission on Mental Health scheduled two presentations about Wraparound Milwaukee as part of an effort to identify successful models of mental health services.

Information about the program is posted on the Web at <www.wrapmilw.org>. ■



This chart gives a breakdown of expenditures for services provided to children and their families under the Wraparound Milwaukee program.

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Insurance Premiums

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health care increased from 4 percent to 7 percent. However, the percentage of covered workers with unlimited coverage for inpatient care also increased from 16 percent to 18 percent.

Gabel told the audience that employers and health plans had responded to consumer pressures by retreating from many of the restrictive elements of managed care and that those changes were reflected most dramatically in HMOs, which are most tightly managed.

The profile of mental health coverage by type of plan suggests support for that view. HMOs showed a slight trend upward in terms of number of visits and days covered.

Gabel told *Psychiatric News* that with the support of funds from the MacArthur Foundation, Richard G. Frank, a professor of health economics at the Harvard Medical School, will analyze trends in mental health benefits from 1997 using data from the KFF-HRET surveys. He anticipates the results will be published in *Health Affairs* in 2003.

Altman told the audience that the "most powerful and surprising finding" of the survey was the breadth of the impact of the combination of "rising health care costs and a sputtering economy." Deductibles, as well as premiums, rose.

For PPOs (preferred provider organizations, the most common type of health care plan, covering about half of all workers), the average deductible increased 37 percent, to $276.

Copayments for prescription drugs continued to climb, averaging $9 for generics, $17 for preferred drugs (brand name drugs with no generic substitutes), and $26 for nonpreferred drugs (brand name drugs with generic substitutes).

Seventeen percent of the firms with covered workers reported benefit decreases, and 10 percent of the firms reported benefit increases.

Retiree benefits are also being affected. In 2002, 40 percent of firms with 200 or more workers reported that they had increased the retiree share of health care premiums in the past two years. Nine percent reported that they had eliminated retiree health benefits for new employees.

In yet another omen, 65 percent of firms with 200 or more workers said that health insurance caused the greatest "cost concern" for their company. By contrast, only 20 percent, the next highest figure, expressed concern about salaries.

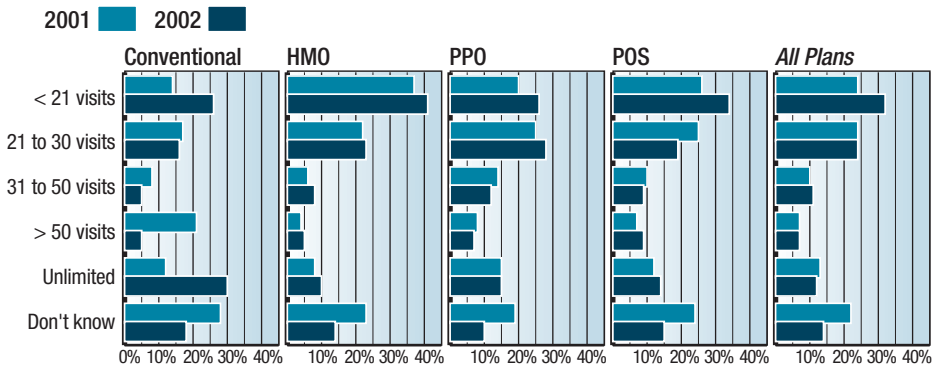
Norman A. Clemens, M.D., chair of APA's Committee on APA/Business Relations, told *Psychiatric News*, "This bleak picture of declining coverage makes our efforts to reach the business community more important. We must work even more vigorously to make our case that insurance coverage promoting access to quality mental health services will benefit employers as well as employees."

Lawrence B. Lurie, M.D., chair of APA's Committee on Managed Care, emphasized the importance of looking at the functioning of the total health care system. He told *Psychiatric News*, "We have to start identifying specific sources of inefficiencies and waste, as well as considering methods of restructuring how we pay for and deliver health care. Excessive administrative costs at managed care companies and unnecessarily high marketing costs for prescription drugs are two items that come to mind."

The survey reported findings from telephone interviews with 3,262 randomly selected public and private employers. Firms range in size from enterprises with as few as three workers t corporations with more than 300,000 employees.

The 2002 Employer Health Benefits Survey is posted on the Web at <www.kff.org/content/2002/20020905a/>. ■

Outpatient Visits Show Slight Decline



Source: The Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, 2002 Annual Survey

In the 2002 survey, 32 percent of employers reported that they pay for fewer than 21 visits for mental health care. The corresponding figure for 2001 is 24 percent. Other categories show little change.

9/11 Care

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ment referral network. Since September 11, many of our members have volunteered to assist traumatized individuals. Disaster Psychiatry Outreach in New York City recently asked us to contact our members about taking on firefighters who live in outlying areas of the city as new patients. Treatment sessions would be reimbursed by the federally funded Liberty Project," said Nininger.

The American Red Cross press release announcing the mental health service plan and other aspects of its long-term September 11 Recovery Program is posted on the Web at <www.redcross.org/press/disaster/ds_pr/020821longterm.html>. A press release from the September 11th Fund is posted on the Web at <www.uwnyc.org/sep11/pr_jul11_02.html>. ■