Volume XXXVII
Number 23
December 6, 2002

Newspaper of the
American
Psychiatric
Association

PSYCHIATRIC NEWS

"see" references appear on pages 8, 17, 43, 63

From left: Scott Waterman, M.D., Paul Newhouse, M.D., Terry Rabinowitz, M.D., Richard Bernstein, M.D., are presented with APA's Profile of Courage Award at last month's APA Assembly meeting in Washington, D.C. The four psychiatrists risked their jobs to protest a plan to segregate psychiatric care. See story below.

Association News

Assembly Honors Psychiatrists For Courageous Stand

In addition to presenting its Profile of Courage Award, the Assembly also approved adding an "education option" to the list of ethics sanctions and passed various patient-care proposals.

BY KEN HAUSMAN

Last May, after considering not-very-veiled threats to their jobs, four Vermont psychiatrists decided to testify at a public hearing against a proposal by their employer to move the inpatient psychiatric unit miles away from the rest of the medical campus. For taking this risk on behalf of patient care, the group won the APA Assembly's 2002 Profile of Courage Award.

Scott Waterman, M.D., Terry Rabinowitz, M.D., Paul Newhouse, M.D., and Richard Bernstein, M.D., are all on the faculty of the University of Vermont medical school and employed by Fletcher Allen Health Care, which runs the state's only academic medical center.

Fletcher Allen had already run into considerable opposition to its plan to relocate psychiatric care away from the main medical center, including from APA, the Vermont Psychiatric Association, and citizen advocates. The protests led to a hearing by the state's Public Oversight Committee at which the four psychiatrists agreed at the last minute to be witnesses against Fletcher Allen's plan (*Psychiatric News*, June 7). Their testimony played a significant role in the oversight committee's unanimous decision to rule against the hospital's request to segregate psychiatric care.

Newhouse said he was accepting his award "on behalf of all individuals and groups who came together to fight this misguided plan," which Waterman said was

please see ***Assembly Meeting*** *on page 4*

Government News

MH Commission Avoids Crucial Funding Issues, Appelbaum Says

"Something is terribly wrong, terribly amiss, with the mental health system," says the New Freedom Commission on Mental Health. APA responds that the commission has unreasonably limited its scope of inquiry.

BY KATE MULLIGAN

The President's New Freedom Commission on Mental Health has "unreasonably limited" its examination of problems with the mental health system by focusing exclusively on budget-neutral solutions, APA President Paul Appelbaum, M.D., said in a recent press statement.

At a November 1 press conference, commission chair Michael F. Hogan, Ph.D., issued an interim report describing the barriers to the delivery of effective mental health care. The commission is scheduled to deliver its full report, with recommendations, to President George W. Bush by May 2003.

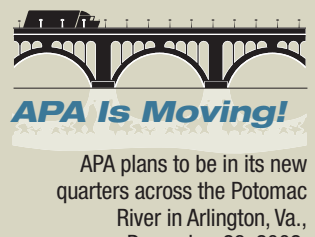
Appelbaum said a "broad societal response" is necessary to the "perilous state of financing for mental health." In particular, he cited the problems of unequal access to private insurance coverage for mental health and in reimbursement for mental health treatment under Medicare.

He told *Psychiatric News*, "Cuts in Medicare reimbursements, the surrender of the Medicaid program to managed care companies, and reductions in state-funded programs for patients with serious mental illnesses have created a crisis situation in many states that must be addressed."

Appelbaum called for Congress to pass and send to the president a comprehensive mental health parity bill requiring equal coverage for mental illnesses and other medical illnesses.

Hogan said at the press conference,

please see ***Commission*** *on page 63*



APA plans to be in its new quarters across the Potomac River in Arlington, Va., on December 23, 2002.

Here's how to contact us.
Address:
1000 Wilson Boulevard, Suite 1825
Arlington, Va. 22209-3901
Phone numbers:
Toll free: (888) 35-PSYCH
Local: (703) 907-7300
APPI order lines:
Phone: (800) 368-5777
Fax: (202) 789-2648

Also in This Issue. . .

This issue of *Psychiatric News* contains two special sections that members should be sure to review:

ANNUAL ELECTION SECTION, which begins on page 19, contains information on the candidates in APA's 2003 election and the amendment to the Bylaws on which members are being asked to vote.

APA: YOUR PROFESSIONAL HOME, which begins on page 37, highlights APA's latest accomplishments in advocacy, education, and research and gives updates on member benefits and practice and CME opportunities.

FDA Likely to Approve Antipsychotic To Prevent Suicidal Behavior

Clinical & Research News

The controversial atypical antipsychotic medication Clozaril is poised to become the first drug to carry an "antisuicide" indication.

BY JIM ROSACK

Novartis Pharmaceuticals last month won the influential support of the Food and Drug Administration's Psychopharmacological Drugs Advisory Committee (PDAC) for the company's application to label Clozaril (clozapine) "for the treatment of emergent suicidal behavior in patients with schizophrenia or schizoaffective disorder."

The PDAC's vote was 8 to 0 in favor of the indication, with one abstention. Although the FDA is not bound by the vote—final approval rests with agency regulators, not the advisory committee—the agency only rarely disagrees with committee recommendations.

If the FDA does grant final approval, which according to FDA documents is highly likely, the drug will become the first medication to be indicated for suicidal behavior.

The PDAC meeting, held November 4, was unusual in that the committee was asked to consider an application for marketing of a drug that the agency had already deemed approvable. More commonly, the committees are asked to weigh in on a drug application prior to any official action by the agency. However, according to Thomas Laughren, M.D., the FDA's team leader for psychiatric drug products, the agency had reached a preliminary conclusion that the drug was approvable, yet questions remained.

"There are questions and issues of sufficient importance," Laughren told committee members, "that we felt it would be useful to bring this application to the PDAC for independent feedback prior to our taking a final action."

The FDA first asked the committee to consider whether the agency's concerns about the methodology of the primary clinical trial submitted to support the application were sufficient enough to block approval. Second, the agency asked the committee to determine whether the single trial was sufficient to prove the medication safe and effective.

"Ordinarily, of course," Laughren said, "at least two adequate, well-controlled trials are required. However, effectiveness can also be established on the basis of a single well-controlled trial and 'confirmatory evidence.' "

Third, Laughren noted, the agency was seeking input on the new claim itself, a drug to be used specifically to treat suicidal behavior.

The single clinical trial submitted by Novartis was the International Suicide Prevention Trial (InterSePT). The study involved 980 patients with schizophrenia or schizoaffective disorder in 11 countries.

The investigators sought to study the comparative rates of hospitalization for imminent risk of suicide and significant suicide attempts in high-risk patients randomly assigned to receive either clozapine (300 mg to 900 mg a day) or olanzapine (Zyprexa) 10 mg to 20 mg a day).

The study was an open-label design with blinded raters, and treating psychiatrists were free to use any interventions, including additional pharmacotherapy, as needed, based on their clinical judgment. This was a significant concern for the FDA. The agency questioned whether the study results were biased by treating psychiatrists knowing which study drug each patient was

please see ***Clozaril*** *on page 57*

Association News

Update on Legal Consultation Plan

APA's Legal Consultation Plan, which has been administered by the law firm Crowell & Moring, will be administered by attorney Anne Marie "Nancy" Wheeler through her private practice as of January 1, 2003. Wheeler has been the primary attorney for the plan since it was established 20 years ago.

The plan allows enrolled members to consult with an attorney on a number of legal issues concerning psychiatric practice including confidentiality, privilege and HIPAA privacy, how to handle a subpoena, risk-management techniques for handling suicidal or dangerous patients, proper termination techniques, and review of managed care contacts. This plan does not offer litigation and related services.

Beginning next year if Wheeler is unavailable, consultation coverage will be arranged through Crowell & Moring or other experienced legal counsel. Referrals to local counsel will be provided if requested.

HIPAA FAQs will be sent by e-mail by December 20 to APA members who join the Legal Consultation Plan. Plan information is available by phone at (202) 508-8721 or e-mail to apaplan@crowell.com.

Why Don't More APA Members Vote?

BY PAUL APPELBAUM, M.D.

Soon after the new year, tens of thousands of ballots will go out in the mail to APA members. But if experience is any guide, only a small percentage of them will be returned. This is, in the words of the King of Siam in Rodgers and Hammerstein's "The King and I," "a puzzlement." Why do so few members exercise their franchise in selecting the leaders of this organization and in setting APA policy?

It was not always so. If you track back voting rates in APA elections, you will find that they have dropped from roughly 50 percent to 60 percent of eligible members in the 1970s (a very respectable figure for any election) to around 40 percent in the 1990s. Two years ago, with Bylaws changes on the ballot to expand the categories of members eligible for fellowship status, the number of members voting on the question fell below the one-third needed to ratify the amendments. Thus, the Board was forced to exercise its powers to approve the changes that the vast majority of those who voted had endorsed. Last year, we hit an all-time low, as only 31 percent of members cast their ballots.

Could it be that members don't think that it makes a difference who their leaders are? Consider what happened at APA's Institute on Psychiatric Services in Chicago this October. At the conclusion of the Opening Session, after my presidential address, I invited the audience of several hundred to stay for a forum with the candidates for president-elect. After brief statements by each candidate, members had an opportunity to ask any question they liked of both contenders. However, as soon as the Opening Session concluded, there was a mad dash for the doors, as if some pharmaceutical company was giving out free umbrellas in the hallway. Thirty or so members stayed, and the discussion was frank and—I thought—helpful. But 30 members represented only a tiny fraction of the people in the room a few minutes before.

If the belief that it just doesn't matter is what's standing in the way of members' voting, I would respectfully suggest that they have it wrong. APA is critical to the future of psychiatry, and APA Board members and officers play crucial roles in directing the organization's efforts and the use of its resources. The initiatives that APA undertakes and how well they are pursued depend on the quality of the leadership that we choose for APA. And candidates are not all the same. The candidates you favor depend on your values.

Do you want a candidate who has had a great deal of experience running organizations, which can be a valuable asset when it comes to managing an association as complex as ours? Or do you value more highly psychiatrists who bring new ideas from the world outside health care systems and organized medicine? How important is it to you that your leaders be skilled public speakers, media spokespersons, and teachers of the public? In any contest there will be candidates who are high energy, full of ideas, and thrive under pressure—is that what you're looking for? Some candidates learned to play well with others in the sandbox, while others are still trying to master the skill; does that make a difference to you? Not every

please see ***From the President*** *on page 62*

Assembly Meeting

continued from page 1

destined "to undermine the clinical and academic work psychiatrists do." Rabinowitz added that the "real heroes are the psychiatric patients who chose to 'out themselves' to ensure their voices were heard." Bernstein singled out advocate Ann Donohue for praise, calling her the "unsung hero" of the battle. Donohue was just elected to the Vermont legislature.

In other actions Assembly members voted to

• **approve adding an "educational option" to the possible sanctions a district branch can impose in response to an ethics-violation charge.** This alternative would not require the district branch to hold a proceeding to determine if a member has violated APA's ethics code or that the member be reported to the National Practitioner Data Bank. The district branch would determine what type of educational program the member would be required to complete, which could include courses, reading, and consultation. The Board of Trustees was scheduled to take up the new ethics option at its November 23-24 meeting.

• **support the formation of an APA office on psychiatric emergency mobilization.** The office, with an estimated annual cost of $65,000 to $85,000, would support the work of the Committee on Psychiatric Dimensions of Disasters by providing for "a national mechanism of mobilization and coordination of psychiatric manpower in the event of terrorist attacks and disasters." It would also make it easier to ensure that there is psychiatric involvement at the local, state, and national levels after a disaster.

• **approve a dues-relief plan for Canadian members.** With the Canadian dollar worth about $0.64 in U.S. dollars, and Canadian members not having access to certain membership benefits such as liability insurance, no-fee credit cards, and federal lobbying efforts, the Assembly agreed that a "rebalancing" of dues was warranted. Canadian members would be assessed at a dues level currently equivalent to $450 Canadian for 2003 if the Board approves the plan, which is estimated to cost APA about $50,400 next year.

• **join a national class-action lawsuit charging managed care companies with violating federal racketeering laws.** The medical societies in five states are suing nine large managed care companies.

• **adopt an APA position statement endorsing the right of same-sex couples to adopt and co-parent children.** Similar statements have been approved by the American Academy of Child and Adolescent Psychiatry and American Psychoanalytic Association.

• **endorse an APA position statement on "Inclusion of Substance-Related Disorders as Psychiatric Disorders in Any Program Designed to Assure Access and Quality of Care for Persons With Mental Disorders."** It is designed to ensure that legislation such as insurance parity proposals specifically include substance-related disorders in their definition of mental illness. Many of these proposals have exempted these disorders from parity coverage.

• **have APA investigate the increasing problems in accessing treatment services** that Medicare and Medicaid beneficiaries with serious and persistent mental illness are facing.

• **have APA develop a strategy for drawing attention to the needs of people with severe and persistent mental illness** and increase its advocacy work on their behalf.

• **have APA develop a resource document to assist members in becoming compliant with HIPAA regulations.** It would be distributed in printed form and on APA's Web site. Several Assembly representatives pointed out, however, that some of the rules will vary among states, and psychiatrists will still need to consult their state medical societies.

• **encourage district branches to assist their resident members in recruiting their colleagues to join APA.**

• ask the Council on Medical Education and Lifelong Learning to explore ways in which APA could **help members prepare for the board-certification and recertification exams.**

• postpone consideration of a proposal to **reduce APA dues by $100 for psychiatrists who also belong to the American Academy of Child and Adolescent Psychiatry (AACAP).** The plan hinged on AACAP's agreeing to reciprocate with its members who also belong to APA. Intended as a strategy to recruit and retain APA members in the face of declining membership numbers, the proposal's failure to include other allied psychiatric organizations and its estimated cost to APA of about $400,000 annually led the Assembly to postpone consideration until its May 2003 meeting.

In addition, Assembly members applauded one of their past leaders, former speaker Dale Walker, M.D., who was this year's recipient of the Area 7 Warren Williams Award. Each of the seven APA Areas can give the award annually to honor a psychiatrist or other individual in that region who has made significant contributions locally, statewide, or nationally.

A draft summary of the actions from the November Assembly meeting is posted in the "Members Corner" area of the APA Web site at <www.psych.org/members/assembly/summaryactionsfinal110902.cfm>. ■

DB Cited for Recruitment Effort

Assembly members from the North Carolina Psychiatric Association (NCPA) accept the Assembly's new District Branch Best-Practices Award at the Assembly's November meeting in Washington, D.C. Pictured are (from left) NCPA Representative **Nicholas Stratas, M.D.;** Women Psychiatrists Representative **Diana Dell, M.D.;** Lesbian, Gay, and Bisexual Psychiatrists Representative **Margery Sved, M.D.;** and NCPA Representative **Peggy Dorfman, M.D.** Holding the plaque is NCPA Executive Director **Robin Huffman.**

The award, which was developed and presented by **Gary Weinstein, M.D.,** the Area 5 deputy representative, honors a district branch (DB) that has shared an innovative program with other DBs. The award, Weinstein noted, will promote "cross-fertilization" of successful DB initiatives.

The NCPA was cited for its creative program to recruit and retain members in which all DB committees focused on that issue, regardless of their primary charge. In addition, the NCPA sent letters to all the state's nonmember psychiatrists explaining why they should join and established a statewide referral service that links patients with psychiatrists. It also enhanced its Web site to share more information about itself and to put more CME offerings online.

Veterans Affairs Secretary Honored

At last month's Assembly meeting in Washington, D.C., Assembly Speaker **Albert Gaw, M.D.** (left), presents an award to **Anthony Principi**, secretary of the U.S. Department of Veterans Affairs. Principi received the Speaker's Award for his long "commitment to ensuring that all veterans have access to the highest-quality health care and benefits to which they are entitled," said Gaw.

Gaw cited Principi's efforts to ensure that Persian Gulf War veterans with posttraumatic stress disorder receive necessary care and his development of a program in which the VA "purchases and manages community housing for seriously mentally ill veterans who are engaged in therapeutic work programs."

In accepting the award, Principi stressed, "Every VA patient with a mental illness has the right to compassionate and effective treatment for his or her disease." The VA, he added, cannot "shunt veterans off to one side of the social tracks simply because the effects of their illnesses may make others uncomfortable."

He noted that in 2001 the VA provided mental health care to nearly 900,000—or 20 percent—of the country's veterans.

Candidates Announced

The Assembly Nominating Committee announced the candidates who will compete for the speaker-elect and recorder posts in next year's election. The candidates for speaker-elect will be the Assembly's current recorder, James Nininger, M.D., of New York and Jo-Ellyn Ryall, M.D., of St. Louis, who is the Area 4 deputy representative.

The race to succeed Nininger as Assembly recorder pits Louis Moench, M.D., of Salt Lake City, against Joseph Rubin, M.D., of Portland, Maine. Moench is the Assembly's Area 7 representative, and Rubin represents Area 1.

The election will be held at the Assembly's next meeting, which will be in San Francisco in May, just prior to the opening of APA's 2003 annual meeting.

At that time, the current speaker-elect, Prakash Desai, M.D., will step up to the speaker's post, replacing Albert Gaw, M.D.

Jay Cutler, J.D. (left), director of the APA Division of Government Relations for more than 20 years, poses with former APA medical director **Melvin Sabshin, M.D.,** after Cutler was presented an award named in Sabshin's honor. Sabshin had served as APA medical director for 23 years. The award honors an APA staff member for service above and beyond the call of duty.

APA Medical Director **Steven Mirin, M.D.,** who presented the award at last month's Assembly meeting, selected Cutler for the honor because of his forceful advocacy at the federal and state levels on behalf of psychiatrists and people with mental illness. These efforts have led to accomplishments such as the 1996 parity law, elimination of the dollar cap on Medicare's outpatient psychiatric services, termination of the Defense Department's experiment with training psychologists to prescribe, and substantial increases in the federal budget for biomedical research and mental health services for veterans, children, and Native Americans.

Anxiety Screening Project Seeks A Few Good Psychiatrists

Psychiatrists have until February to be a part of National Anxiety Disorders Screening Project 2003.

BY EVE BENDER

Freedom From Fear, the New York–based organization that sponsors National Anxiety Disorders Screening Day, and APA, which cosponsors the event, are encouraging psychiatrists to sign up for the 2003 National Anxiety Disorders Screening Project (NADSP).

NADSP will be held May 7, 2003, to coincide with National Anxiety Disorders Screening Day, which is held annually at sites across the U.S. and Canada to screen people for anxiety and depression, guide those who need treatment to psychiatrists and qualified mental health professionals, and educate the public about mental illness.

Psychiatrists who register for the screening project will receive materials to help with screening, education, and promotion of NADSP, which include a planning and promotion guide and CD-ROM with screening form, fact sheets for patients on anxiety disorders and depression, and promotional materials. Most of the materials can be modified to add the physician's name and contact information.

New this year is an educational film on social anxiety disorder, hosted by entertainer Donny Osmond.

The deadline for registration is February 24, 2003. A one-time fee for participating health professionals is $100.

Those who register to provide screening are expected to review the screening form at no cost. If the screening form reveals that a person has an anxiety or depressive disorder, the psychiatrist can either treat the person or refer the person to a qualified professional in the community.

Screening professionals are listed on the Freedom From Fear Web site's "Referral Room," so that people wishing to get screened and treated have a ready list of clinicians to whom they can turn. Their names and contact information can also be accessed through the organization's toll free number at (888) 442-2022.

Since NADSP was established in 1994, more than 500,000 individuals have been screened for anxiety and depressive disorders.

Those wishing to register for the National Anxiety Disorders Screening Project or learn more about it can contact Jeanine Christiana at (718) 351-1717 or go the Web at <http://www.freedomfromfear.com/commread.asp?id=38>. ■

JANSSEN PHARMACEUTICA

P4C

JANSSEN PHARMACEUTICA

P4C

AACAP to Step Up Search For More Child Psychiatrists

The American Academy of Child and Adolescent Psychiatry announces an ambitious strategic plan to attract more medical students, residents, and practicing physicians into the subspecialty.

BY CHRISTINE LEHMANN

The American Academy of Child and Adolescent Psychiatry (AACAP) issued a bold call to action at its annual meeting in San Francisco in October to increase the number of child and adolescent psychiatrists by 10 percent annually for 10 years beginning in 2004.

The call to action was taken to reverse the shortage of child and adolescent psychiatrists in the United States. There are about 6,300 of these specialists to care for the 15 million children and adolescents who need their services, according to the strategic plan, "A Call to Action: Children Need Our Help."

"We must examine our training programs to understand how we can attract more bright young medical students into the profession," said AACAP President Marilyn Benoit, M.D., at the meeting.

The strategic plan focuses on three initiatives to promote interest in the subspecialty. They involve creating an attractive image of child psychiatry, developing flexible training programs, and supporting strategies to increase child psychiatrists' reimbursement rates and funding for residents and training programs.

Lois Flaherty, M.D., chair of the APA Council on Children, Adolescents, and Their Families, commented in an interview with *Psychiatric News*, "The plan represents an impressive commitment of resources by AACAP and a multipronged approach to recruitment that can be implemented simultaneously."

Inadequate recruitment into child and adolescent psychiatry has persisted for several years, said Flaherty. "Despite numerous conferences and discussions, not much has changed in terms of actual initiatives with the exception of the triple-board program [see story below], which exists only in a few medical centers and is not contributing much to the pool there."

She continued, "I think the two most important initiatives in the strategic plan are supporting legislation to allow loan forgiveness for medical students, sponsored by Rep. Patrick Kennedy [D-R.I.], and developing flexible pathways to training in child and adolescent psychiatry, such as the four-year concentration [in that field] that would allow pediatricians direct entry."

The first initiative calls for AACAP to increase its communication to medical students and general psychiatry residents, expand mentoring opportunities, and develop a public relations campaign to counter negative images of the profession.

The Steering Committee on Work Force Issues, which developed the strategic plan, has held focus groups with minority medical students and general psychiatry residents to determine barriers to recruitment, according to co-chair Tom Anders, M.D. Many minority medical students reported that they became interested in the subspecialty through mentors or other child and adolescent psychiatrists they met during their psychiatry rotation, according to a summary of their group meeting.

Marilyn Benoit, M.D.: "We must examine our residency training programs to understand how we can attract more bright young medical students into the profession."

They also reported,

please see ***AACAP*** *on page 58*

Child Psychiatrists See Triple-Board Programs as Recruitment Tool

AACAP unveils a strategic plan that calls for increasing the number of triple-board programs as a way to enhance recruitment of child psychiatrists.

BY CHRISTINE LEHMANN

The strategic plan recently initiated by the American Academy of Child and Adolescent Psychiatry (AACAP) (see story above) recommends creating five new triple-board programs by 2008 to expand the pool of practicing child psychiatrists.

The triple-board program takes five years to complete and includes two years of pediatrics training and three years (1.5 years each) of adult and child and adolescent psychiatry training, said Tom Anders, M.D., co-chair of the AACAP Steering Committee on Work Force Issues, in an interview with *Psychiatric News*.

"Each new triple-board program would have two child psychiatry training slots. By adding a new program annually starting in 2004, there would be 10 new board-eligible child and adolescent psychiatrists by the year 2013," said Anders.

Gregory Fritz, M.D., the steering committee's other co-chair, said in an interview, "If this effort is to succeed, we will have to obtain new sources of funding to support the two additional training slots and publicize the programs to attract sufficient numbers of applicants."

The federal government continues to limit the number of funded graduate medical education residency training positions, which puts pressure on directors to maintain the status quo unless there is outside funding, said Fritz. "There is also a bias against the triple-board programs among some department chairs who believe that they produce 'a jack-of-all-trades and a master of none.'

Gregory Fritz, M.D.: "Residents who complete triple-board programs are highly qualified to practice and in great demand in the job market."

"There is no evidence to support that view, Fritz said. "Residents who complete triple-board programs are highly qualified to practice and in great demand in the job market. However, the pool of applicants has remained relatively small."

It was clear from the focus group on minority medical students that AACAP held recently that many of them were unfamiliar with triple-board programs. "We must do a better job of publicizing the programs if we are going to succeed in attracting more students and expanding the number of programs," said Fritz. ■

Back to the Future? Psychiatrists Urged To Re-Engage With Community

One psychiatrist would like to turn the clock back to a time when psychiatry paid more attention to community needs and social issues.

BY MARK MORAN

Psychiatry needs to rediscover its roots in the community, lost in the movement to "remedicalize" in the last two decades, said Kenneth Thompson, M.D., at APA's 54th Institute on Psychiatric Services.

Seeking to "reconceptualize psychiatry as a public health discipline," Thompson urged clinicians at the conference to forge links with partners in the community. These include patients and families, academic institutions, community mental health centers, and public health departments.

He said psychiatry had a critical role to play in advocating for community housing, development, and economic revitalization.

Thompson is an associate professor of psychiatry and public health at the University of Pittsburgh School of Medicine and director of the Institute for Public Health and Psychiatry at Western Psychiatric Institute and Clinic in Pittsburgh. His comments in a lecture at APA's institute prompted a response from one psychiatrist in the audience who complained about the "complete lack of leadership" at APA in providing support and direction to clinicians working in the community.

Thompson replied that there are psychiatrists within the Association and its leadership who are trying to help psychiatry restore its engagement with the community. However, he said, it was "highly problematic" that the profession had become "so socially disengaged it has seemed to become narrowly focused on guild issues."

He said psychiatry had moved away from its roots in the community as a reaction to what was perceived by some as the "arrogance" and over-reaching of the community mental health movement in the 1960s in its efforts to effect broad social change.

Thompson said the profession's increasing disengagement from the community stemmed from the fear of not being funded in the era of biological psychiatry and molecular genetics.

"It has caused us to remedicalize ourselves in a reductionistic fashion," he said. "Now we have gone in the opposite direction, backing away from any social engagement, with a narrow focus on molecules."

Thompson said the revolution in molecular genetics has siphoned attention from what are well known to be among the most potent factors in health and illness—social and economic factors. "When you ask the question, 'What makes some people healthy?,' people today say, 'Genes.' But that is grossly inaccurate. We know a great deal more about the social determinates of health and illness. The most robust finding is that social class and socioeconomic status are entirely related to the burden of health and illness."

For psychiatrists interested in engaging the community, it is crucial to know where the burden of illness is, Thompson said. That is one reason why practicing clinicians need to partner with health departments and other agencies that have access to population-based health data. He noted that the department of public health in Pittsburgh was virtually alone among municipal or state health departments in including a mental health component as part of its annual Behavioral Risk-Factor Survey.

Thompson suggested that an exclusive focus on pathogenesis should be replaced by a counterbalancing understanding of "salutogenesis"—the processes that produce health.

He said it is possible to identify patterns of behavior that make for healthy communities and that psychiatrists can play a crucial part in encouraging such patterns.

Citing seven patterns of salutogenesis, Thompson said healthy communities practice ongoing dialogue among their members,: embrace diversity, have an active interest in shaping the future, have a knowledge and understanding of themselves and their problems and weaknesses,; generate leadership, connect people and resources, and create a sense of community.

Thompson suggested that the common element in these patterns is the ability on the part of community members and stakeholders to form relationships across conventional boundaries. And he noted that he teaches residents to think of themselves and their patients as "social molecules," building bridges to others in the community.

"In the information era, expertise is less in the possession of knowledge and more in the relationship between people with knowledge," he said. ■

Stress Occupational Hazard For Forensic Psychiatrists

The adversarial nature of forensic psychiatry would appear to make it a particularly stressful specialty. A new study explains how accurate that perception is.

BY KEN HAUSMAN

Many psychiatrists maintain that the stresses of forensic psychiatry appear so enormous, they don't understand why any of their colleagues would choose to specialize in that field.

They may cite, for instance, one common scenario facing forensic psychiatrists in which a community is outraged to find it has a dangerous, violent person in its midst. Public opinion will be content with nothing less of a jury than meting out the most severe punishment possible. Confronting the community's anger and the media's spotlight, a forensic psychiatrist offers the expert but unpopular testimony that the defendant shows signs of serious mental illness that may meet the state's definition of insanity.

AAPL President Larry Strasburger, M.D., notes that experience and gender play a role in the degree to which forensic psychiatrists are stressed by their work.

Add to this situation the potential stressors of poorly prepared attorneys, juries suspicious of psychiatric expert witnesses, and opposing attorneys whose tactics include questions about the expert's professional capabilities and personal life, and it's no wonder that stress is viewed as an inescapable part of forensic psychiatry.

But is it really?

Larry Strasburger, M.D., president of the American Academy of Psychiatry and the Law (AAPL), conducted a study to assess the level of stress experienced by forensic psychiatrists. Whether stress is in fact "an occupational hazard" for forensic psychiatrists is a topic that had not previously been a subject for research, he noted. The study's results were the focus of his presidential address at the annual meeting of AAPL in October in Newport Beach, Calif.

Strasburger mailed questionnaires to 1,800 AAPL members, of whom 370 completed the survey. The respondents had been in forensic psychiatry for a mean of 15 years and said they work on a mean of 30 cases annually. They were asked to rate 62 specific stressful experiences for frequency and severity.

The questions fell into three general areas or factors—what professional situations cause anxiety, how much respondents somatized in connection with their work, and whether psychiatrists become desensitized.

The responses showed that while stress is clearly a component that many forensic specialists have to process, respondents reported an overall stress level that was generally low—certainly lower than what many of their nonforensic psychiatric colleagues would have predicted, Strasburger noted.

He pointed out that with 78 percent of respondents indicating that they enjoyed the challenges of their specialty, forensic psychiatrists appear to be "physiologically and psychologically a resilient, healthy group."

Which is not to say, however, that stress fails to rear its ugly head for a substantial number of forensic psychiatrists. About 50 percent said, for example, that serving as an expert witness—a major part of many forensic specialists' work—causes them at least moderate stress, while a nearly equal number indicated that doing so provoked little or no stress.

There are, however, elements of the expert-witness role that are more stress-inducing than others, Strasburger said. The situation most often cited by AAPL members was not being able to defend one's opinions during cross-examination—58 percent found this highly to extremely stressful. Other frequently cited stressors were having one's personal history revealed in court, working under tight deadline pressure, having to testify in a proceeding the forensic psychiatrist viewed as a "gross miscarriage of justice," being cross-examined while physically ill, being questioned by attorneys who try to coerce a particular opinion from the forensic expert, testifying in high-profile trials, and talking to the media.

He cited several reasons that likely explain why these situations are particularly stress provoking for forensic psychiatrists.

"First, psychiatrists are trained in alliance building, not adversarial relationships," Strasburger said. "Second, skills such as empathy, compassionate care, and standing in the patient's shoes—skills that took a long time to acquire—are no longer paramount."

In addition, the forensic specialist "must display her expertise in a public forum, subject to ridicule and humiliation," he added. "The process of making mistakes and learning from them is a hazard to self-esteem if it occurs in an environment in which an opposing attorney is deliberately attempting to diminish the stature of the expert."

Strasburger hypothesized that four variables might be key to trying to predict how stressed the survey respondents became in professional situations—the number of years of forensic practice, number of cases they undertook each year, the psychiatrist's gender, and the extent to which respondents rated themselves as "enjoying feeling stressed."

Only two of these variables turned out to be statistically significant stress predictors for forensic psychiatrists. "The more

please see ***Stress*** *on page 41*

Federal Privacy Rule: Contradiction in Terms?

Must psychiatrists disobey the Hippocratic Oath to keep their place on managed care panels? The answer is yes, according to opponents of the new federal medical privacy rule.

BY EVE BENDER

United States citizens are in danger of having their medical information broadcast to data-processing and insurance companies, hospitals, and researchers without their prior consent or knowledge, according to opponents of the final medical privacy rule who appeared at a press conference sponsored by the Institute for Health Freedom (IHF).

IHF President Sue Blevins appeared at the National Press Club in Washington, D.C., in October to speak out against the Bush administration's modifications to the rule, published on Aug. 14 by the Department of Health and Human Services (HHS) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (*Psychiatric News*, September 6, 2002).

Institute for Health Freedom President Sue Blevins: "People in this country will soon have to choose between health care and privacy."

"People in this country will soon have to choose between health care and privacy," Blevins said.

Under the new rule, "covered entities," which include clinicians, hospitals, clinics, insurers, and data-processing companies, have federal permission to access patients' health information. Under the new rule, medical records can also go out to business associates of these entities, such as attorneys, consultants, and accountants, until April 2004. By this date, the business associates must comply with privacy protections in the rule. Until that time, medical information can be disclosed to the associates even if they are not in compliance with the protections.

The modifications also eliminated the standard in which doctors must get patients' consent before releasing their personal health information, including genetic information, for purposes of treatment, payment, or "health care operations," a broadly defined term that encompasses fundraising and insurance-fraud detection.

Personal medical information can also be divulged to government agencies that check medical records for Medicare fraud.

The rule took effect on October 15 and can be applied retroactively. That means patient medical records from the 1970s, for instance, are not protected.

Misleading Information?

Blevins said that HHS has been misleading the public about the federal medical privacy rule and its effect on medical privacy ethics. "HHS tells the media that the rule improves citizens' medical privacy, when in fact it does just the opposite."

Blevins questioned information posted about the federal rule on the HHS Web site under a section titled, "Frequently Asked Questions About the HIPAA Privacy Rule" which, she said, leads the public to believe that their personal information won't be compiled in government or private databases without their consent.

"While the rule does not require the creation of such databases, it does not prevent them from being created," she said.

Furthermore, HHS says that Americans can get an accounting of their medical record disclosures, and this isn't necessarily true, according to Blevins. "HHS says that for the first time ever, patients will get an accounting of disclosures, but here's the trick—your records can be shared without your permission or knowledge for treatment, payment, and health care operations."

"It's like saying that you can see who accesses your credit report, but that you'll only see when your credit report is released for anything other than your credit history," she added.

Practical Implications Troubling

Health care attorney Jim Pyles, J.D., is troubled by the removal of federal protection for the right of consent, but even more disturbed by the fact that "this is your federal government giving license to more than 600,000 covered entities in this country to get your medical information—the lawyer in me is extremely offended by this."

Pyles, who serves as counsel for the American Psychoanalytic Association on privacy issues, said that if one of these entities demands a patient's medical information from a doctor, the doctor has the right to refuse to divulge the information.

But physicians can pay a price for refusing to disclose medical records, according to Pyles, who recently offered expert testimony in a Pittsburgh court case in which a managed care company demanded that a local psychiatrist submit medical and mental health records of each patient enrolled in the plan. The company threatened to remove the psychiatrist from its provider panel unless he forfeited the records, Pyles said.

The psychiatrist refused to divulge the records on the grounds that his patients trusted him to keep their information confidential, and the insurance company then removed him from the plan. The psychiatrist obtained an injunction, and the presiding judge is seeking to establish whether the insurance company acted within the law when it removed the psychiatrist from the plan. No verdict had been reached by press time.

"This is an example of the pressure that will be brought to bear on practitioners, even though the Bush administration tells them they have a choice to refuse to divulge medical information."

please see ***Privacy Rule*** *on page 58*

BMS ABILITY
P4C

DB Recognizes Importance Of Community Education

An APA district branch honors several community members who are educating the public about mental illness.

BY EVE BENDER

Community support characterized an October meeting of the West Hudson Psychiatric Society (WHPS) in New York, where high school students, mental health advocates, and district branch members have united in the fight against mental illness.

Nearly 100 people gathered at the Dellwood Country Club in New City, N.Y., for an educational lecture and two award presentations.

Present at the meeting were more than 20 members of the Rockland County Mental Health Coalition, a mental health advocacy group formed by West Hudson District Branch President Lois Kroplick, D.O., in 1996.

Coalition members are representatives from hospitals, government offices, and mental health organizations in Rockland County, such as the local chapter of the National Alliance for the Mentally Ill. The group's mission is to fight stigma surrounding mental illness.

According to Kroplick, the group promotes its mission in various settings in Rockland County. "We go to local elementary schools and put on improvisational skits for the students dealing with issues such as bullying, divorce, and depression," she told *Psychiatric News*. Following the skits, teachers and mental health professionals field questions from students and explain the issues enacted in the skits.

Coalition members with mental illness and their families also speak at area colleges in the coalition's College Education Program and in public in the Breaking the Silence Public Forum about their experiences with mental illness and recovery.

The woman who is largely responsible for the success of these programs is Rena Finkelstein. She is co-president of the local chapter of the National Alliance for the Mentally Ill, NAMI-FAMILYA of Rockland County, chair of the coalition's college education program, and co-chair of the Breaking the Silence Public Forum.

During the meeting, Kroplick presented Finkelstein with an award for her outstanding work as an advocate for people with mental illness and their families.

Rena Finkelstein, M.D. (right), receives an award from Lois Kroplick, D.O., for her outstanding work as an advocate for people with mental illness and their families.

In addition, three high school students received awards for winning the "When Not to Keep a Secret" essay contest, a national endeavor begun by the APA Alliance in 1998. In the contest, ninth and 10th graders write essays about the importance of confiding in an adult when a peer has a serious problem.

In Rockland County contest winners Ashley Globerman, Mondaire Lamar Jones, and Stephanie Mostecak wrote about how they confided in adults when they learned their friends were planning to commit suicide or were facing problems such as violence and sexual abuse. Each student won a $100 honorarium and certificate.

"When Not to Keep a Secret" essay contest winners (front row) Stephanie Mostecak, Ashley Globerman, and Mondaire Lamar Jones pose with Lois Kroplick, D.O., founder and past president of the Rockland County Mental Health Coalition and president of the West Hudson Psychiatric Society. In the back row are Janet Oberman, Ph.D., co-president of the Rockland County Mental Health Coalition; Sherry Glickman, C.S.W., past president of the coalition; and Dom Ferro, M.D., co-president of the coalition and public affairs representative for the West Hudson Psychiatric Society.

Meeting attendees also heard a lecture on the neuropsychiatry of Lyme disease presented by two faculty members at Columbia University. Brian Fallon, M.D., M.P.H., an associate professor of clinical psychiatry, and Carolyn Britton, M.D., an associate professor of clinical neurology, spoke about the depression, anxiety, and cognitive problems that often accompany Lyme disease.

"This meeting was so special because it united the mental health community and recognized those who have done outstanding work in helping to destigmatize mental illness," Kroplick told *Psychiatric News*. ■

WPS Award Honors Work Of Sen. Paul Wellstone

The Washington Psychiatric Society commemorates the loss of one of the strongest supporters that people with mental illness and their families have ever had on Capitol Hill by creating an award in memory of him and his wife.

The untimely death of Sen. Paul Wellstone while he was campaigning for re-election in Minnesota in late October has left the mental health community reeling. The Washington Psychiatric Society (WPS) decided to do something positive with its grief by creating the Sen. Paul and Mrs. Sheila Wellstone Mental Health Visionary Award in memory of the years of hard work that he and his wife had devoted to mental illness causes.

The first award was presented last month to Ellen Gerrity, M.D., the senator's senior mental health policy advisor, who accepted the award posthumously on behalf of Wellstone and his wife. The presentation was made by Eliot Sorel, M.D., chair of the WPS Partnership for Parity Working Group and former WPS president.

"The WPS plans to present the award annually to a well-deserving advocate," Sorel told *Psychiatric News*, "and it will bear the names of Sen. and Mrs. Wellstone in perpetuity."

After accepting the award, Gerrity told those in attendance, "Through this award, the WPS has given solace to his staff and family and all those who loved him, because of its focus on the future. . . . Among the many painful ways we are experiencing grief is the great concern that the hard work of Paul and Sheila might not go on. We ourselves as staff are suddenly facing the necessity of making new choices about how to carry on this work."

Gerrity told a powerful story illustrating that the senator's devotion to those often overlooked by society was never a calculated political position to win votes. A few years ago the National Mental Health Association had invited him to visit the Tallullah (La.) Corrections Facility, which at the time was under investigation by the Department of Justice for alleged abuse of youth there, she said. As the entourage toured the newly painted facility and noticed the boys' new sneakers and plentiful food, Wellstone broke away to sit down with them and ask how they were doing. Next, he asked to see where the boys with mental illness received care. As they walked across the compound to that area, a boy started running toward him, saying "I want to talk to you." As stunned staff officials and reporters looked on, the boy said that what Wellstone had seen so far was a sham and that the young inmates were usually treated very badly, including being beaten. The result was that Wellstone kept an eye on the institution and in March 1999 introduced the Mental Health Juvenile Justice Act. He reintroduced the bill last February (S 1965), and it is now in the Senate Judiciary Committee.

> **"Paul restored hope to the great and the powerful; to the vulnerable, the poor, the ill, to those who have no voice. . . ."**

"Paul restored hope to the great and the powerful; to the vulnerable, the poor, the ill, to those who have no voice; and to those with mental illness and those who take care of them," said Gerrity.

"In Minnesota at the memorial service, 30,000 of Paul's closest friends—and I say that truthfully—came with crushed hearts and left with the vision of Paul and Sheila and the restored hope that with their own dedication and commitment, their work will go on."—C.F.B. ■

Ellen Gerrity, M.D., senior mental health policy advisor for Sen. Paul Wellstone, addresses a gathering of the Washington Psychiatric Society after accepting its first Mental Health Visionary Award last month on behalf of Sen. Paul Wellstone and his wife, Sheila. At left is former WPS president Eliot Sorel, M.D., who presented the award.

AMERICAN PROF
AGENCY
P4C

VIVACTIL
P4C

Canadian Psychiatrists Learn How FBI Identifies Suspects

A retired FBI agent explains to those at the annual meeting of the Canadian Psychiatric Association some of the methods that the FBI uses to identify offenders.

BY JOAN AREHART-TREICHEL

Gregg McCrary of Fredericksburg, Va., is not a psychiatrist. Nonetheless, he has delved into criminal minds for many years—as an agent for the U.S. Federal Bureau of Investigation (FBI). His job was to psychologically profile criminals, work on crime scene analysis, and, in short, helping identify "the bad guys."

Thus, McCrary was invited to give a talk at the annual meeting of the Canadian Psychiatric Association in November on how the FBI goes about identifying offenders. The meeting was held in Banff, Alberta.

McCrary indicated that he found the invitation appropriate. After all, he pointed out, "We deal with the same clientele. We deal with them in the wild, you deal with them in captivity, but there is a lot of overlap."

So what are some of the tools that FBI agents use to identify transgressors?

Probably the one that the public is most familiar with is called "prospective profiling," McCrary said. That is where evidence that has been gathered about a particular type of offender is used to build a composite picture of him or her—say, a typical serial killer or a typical child molester. For example, FBI agents know that sadists often document their acts on video. They know that hard-core child molesters usually keep child pornography material in their possession all their lives. The goal of prospective profiling is to narrow the search for a suspect or even identify the suspect if possible. The problem with prospective profiling, however, is that it often leads to false positives, McCrary pointed out. In other words, there is no one-size-fits-all mold that always accurately portrays a particular criminal type. So on the whole, prospective profiling is not nearly as valuable as is retrospective profiling. Retrospective profiling consists of gathering evidence about a particular suspect to identify him eventually—in other words, what people usually think of as standard police investigations.

FBI agent Gregg McCrary: "It is not magic. You drill down, look at this stuff, and pretty soon you get an idea of whom you are looking for."

Looking at Minute Details

Some of the best evidence for retrospective profiling, McCrary indicated, comes from minute details.

For instance, he and his colleagues were once in communication with kidnappers who wanted ransom money. The agents knew that the kidnappers were a man and a woman by their voices. But some smaller revelations gave the agents even more valuable insights into them.

The kidnappers said that they wanted their ransom money in 10 "Eddie Bauer" bags, indicating that they were, as McCrary put it, a "young yuppie couple." And golden retriever hairs were on one of their letters demanding ransom. Indeed, it turned out that the kidnappers were a fairly affluent young couple with a golden retriever.

Then there were a number of Austrian murder investigations with which McCrary was involved. All showed strangulation with an article of clothing, and the piece of clothing was always tied in a particular knot. McCrary deduced from this evidence that all the murders had been committed by the same person, which turned out to be the case.

Even with such evidence and good psychological profiling, though, FBI agents sometimes have trouble identifying offenders because the offenders are knowledgeable about the latest techniques for identifying criminals, McCrary admitted. For instance, "the high-end guys read publications from true-crime books to the professional literature," he said.

Also, because of their knowledge about DNA evidence, seasoned sex offenders are using condoms more than they used to.

Cleverness Trumps Knowledge

Still other transgressors, McCrary added, are tough to finger, not so much because they are knowledgeable as because they are wily. For example, a child molester pretended to be a witness in his own case in order to mislead FBI agents. A killer attempted to make it look as though he was disorganized, whereas he really wasn't.

*please see **FBI** on page 62*

Justice System Ill Equipped To Treat Mentally Ill Youth

The vast majority of youth entering the juvenile justice system meet criteria for a mental disorder, yet the juvenile justice system is not able to handle their mental health needs.

BY EVE BENDER

Record numbers of youth with mental health problems, including substance abuse, are landing in the juvenile justice system without having their mental health needs addressed. Recent attention to evidence-based interventions and collaboration between service systems, experts say, can stem the growing crisis.

This was the message delivered to attendees at the latest Center for Mental Health Services (CMHS) Insights Speakers Series, "Young People With Mental Health and/or Substance Abuse Disorders in the Juvenile Justice System," held last month in Washington, D.C.

Joseph Cocozza, Ph.D.: "One of the single most important things we can do is to keep young people out of the juvenile justice system."

Evidence points to the fact that rates of mental disorders among youth in the juvenile justice system are two to three times higher than among youth in the general population, according to Joseph J. Cocozza, Ph.D., director of the National Center for Mental Health and Juvenile Justice, operated within Policy Research Associates Inc. (PRA) in Delmar, N.Y.

PRA is a firm that conducts research, policy analysis, and evaluation studies with a primary focus on mental health service issues at the federal, state, and local levels. The center was established last year to promote awareness of the mental health needs of youth in the juvenile justice system and assist in developing policies to help those youth. The center receives funding from the John D. and Catherine T. MacArthur Foundation and the federal Office of Juvenile Justice and Delinquency Prevention.

Scale of Problem

Cocozza cowrote the article "Youth With Mental Health Disorders: Issues and Emerging Responses," which provides an extensive review of research on mental health issues among youth in the juvenile justice system.

In his review, he found that anywhere from 75 percent to 100 percent of youth in the juvenile justice system meet *DSM-IV* criteria for mental illness, including substance abuse. As of 1999, there were more than 108,000 adolescents housed in juvenile or detention facilities across the U.S.

"These aren't necessarily mild cases," Cocozza said, adding that at least 20 percent of these young people have serious mental illnesses such as bipolar disorder and schizophrenia. While some studies measured the severity of illness in terms of diagnosis, others used measures of functioning or need.

Cocozza cited a study by researchers at the Florida Mental Health Institute estimating that about half of all youth with a mental disorder in the general population also have a substance abuse disorder. Noting that there were few sound studies to measure this finding in adolescents who have come into contact with the juvenile justice system, Cocozza estimated that for this population, the proportion with substance abuse issues would likely be higher than 50 percent.

Furthermore, the number of young people with any mental disorder in the nation's juvenile correctional facilities seems to be on the rise, Cocozza noted.

He cited data from the Texas Youth Commission, showing that of 2,123 youth entering juvenile justice facilities in Texas in 1995, 27 percent were categorized as having a severe emotional disturbance, and 47 percent had a substance use disorder. Six years later, in 2001, of 2,406 youth entering these facilities in Texas, 48 percent had a severe emotional disturbance, and 54 percent had a substance use disorder.

However, the commission also found that of the youth with serious mental illness, 67 percent were there for nonviolent offenses. "Most of these young people we could divert out of the justice system if we had something in place to bring them to," Cocozza said.

System Becoming Dumping Ground

"Adding to the growing sense of crisis is the concern that the juvenile justice system is becoming a dumping ground for these kids [with mental disorders]," Cocozza said.

According to a 1999 study commissioned by the National Alliance for the Mentally Ill, 903 families with a mentally ill child responded to a survey about seeking mental health services for that child. Thirty-six percent of parents surveyed said their child was in the juvenile justice system because that was the only setting in which services could be obtained.

"More and more of these kids are entering the juvenile justice system—[whose personnel lack] the training to deal with them," Cocozza explained.

For instance, the Civil Rights Division of the U.S. Department of Justice undertook a series of investigations that documented the inadequacy of mental health care services in juvenile correctional facilities in a number of states, Cocozza said. The investigations found poor or nonexistent screening practices, insufficient clinical services, and inappropriate use of medications, among other problems.

Solutions Proposed

Over the past decade, increased attention by national mental health organizations, the research community, and family and advocacy groups has helped to improve assessment and treatment of youth who come into contact with the juvenile justice system, Cocozza said.

In the last couple of years, juvenile justice facilities in several states have begun to use the Massachusetts Youth Screening Instrument, Version Two (MAYSI-2), a standardized, scientifically proven screening instrument that can be administered by nonclinical staff in under 10 minutes. The instrument identifies mental health problems in youth entering the juvenile justice system.

In addition, researchers have identified successful evidence-based treatments such as multisystemic therapy, functional family therapy, and multidimensional-treatment foster care. These treatments, researchers have found, not only decrease re-arrest rates and decrease psychiatric symptoms, they also save taxpayers money.

A number of interagency programs have sprung up to treat juvenile offenders, Cocozza noted. Mobile mental health treatment teams, for instance, consist of mental health professionals in the community who travel to the juvenile justice facilities to assess and treat young people.

Other collaborative programs prepare juvenile offenders for release into the community and ensure that after release young people have an array of social services at their disposal.

Cocozza emphasized that collaboration between myriad systems, including mental health and substance abuse, education, and social welfare, will help to keep juvenile offenders with mental health problems out of the juvenile justice system.

"We can't do this tomorrow," Cocozza said, adding that with the "tools we have, support, and political will," mental health problems of young people in the juvenile justice system can be alleviated.

More information about the National Center for Mental Health and Juvenile Justice can be found on the Web at <www.ncmhjj.com>. ■

Advocate Strives to Improve MH Care For Girls in Juvenile Justice System

Eighteen years ago Laura Prescott entered the mental health and substance abuse systems to seek solace from a past marred by violence. Today, she is trying to improve how those systems work for adolescent girls.

Many adolescent girls who enter the juvenile justice system have been physically and sexually abused. As a result, they have complex mental health needs, according to one mental health researcher who added a unique personal understanding to a discussion of those needs.

Laura Prescott is president and founder of Sister Witness International Inc., an organization of formerly institutionalized women and girls based in Sarasota, Fla. Prescott appeared with Joseph Cocozza, Ph.D., at the Center for Mental Health Services (CMHS) Insights Speakers Series in Washington D.C., last October (see story at left) to talk about improving services for girls and young women who are in the juvenile justice system and have co-occurring disorders.

Prescott is the author of the 1998 report "Improving Policy and Practice for Adolescent Girls With Co-Occurring Disorders in the Juvenile Justice System" and a survivor of physical and sexual abuse by her grandfather. She has also spent time in juvenile justice and psychiatric facilities.

"The effect of violence from the age of 3 into my 20s shattered my life," Prescott said. "I created internal witnesses in the form of voices that screamed when I couldn't."

She said that when she first entered the mental health and substance abuse systems 18 years ago, she was "looking for a place to fit. . .to articulate the truth of my life and stop hiding." She spent time in a halfway house for women with substance abuse disorders. "Half of them are no longer living," she said.

Prescott said that during the years when she was in and out of mental health and substance abuse treatment centers, homeless shelters, and juvenile justice facilities, she was "trying to erase the truth I knew, . . .and for girls today in the juvenile justice system, there is a use of substances to erase what they know."

The numbers support Prescott's statement. According to her report, 84 percent of female adolescents who come into contact with the juvenile justice system have mental health problems. Studies have found that anywhere from 60 percent to 87 percent are in need of substance abuse treatment.

All too often, however, adolescent girls with both mental health and substance abuse problems cannot find help in one place, Prescott said. When she was an adolescent, she faced this very problem. "In mental health settings, I was told that my substance abuse problems were secondary to the voices I was hearing. In substance abuse, when I heard voices or was self-injured, I was told to get help in a psychiatric setting. In homeless shelters, I couldn't be hearing voices or using substances or I didn't qualify [to stay there]."

Another problem Prescott has identified is that adolescent girls with abuse histories

"I don't want to wait until girls violently act out before we hear what they are trying to tell us, which is that they are in trouble."

may be given a label by schools or mental health systems that turns out to be a self-fulfilling prophecy.

"A part of my giving up was that I lived up to my conduct-disorder label," Prescott said.

She described days during her fifth and sixth grade school years when she would "wake up from a night of being with my grandfather, a night of abusing substances, and walk into the classroom with a learning disability. People asked me why I wasn't paying attention." She said the context of her life was not taken into consideration,

*please see **Advocate** on page 63*

NAMI Plans Big Expansion Of Antistigma Campaign

The National Alliance for the Mentally Ill leaves no stone unturned in its new campaign to promote education about mental illness.

BY EVE BENDER

An ambitious new mental health campaign is targeting everyone from high school students to political candidates to raise awareness about mental illness and promote recovery.

The National Alliance for the Mentally Ill (NAMI) announced its newest initiative, "The Campaign for the Mind of America," in early October. The campaign includes an expansion of NAMI's educational and antistigma efforts.

NAMI is a mental health advocacy organization composed of 220,000 members, including people with mental illness and their families.

"The campaign is about convincing taxpayers and legislators that there are opportunities for excellent treatment in our mental health system," said NAMI Executive Director Richard Birkel, Ph.D. This knowledge is especially important for "would-be consumers," he said, who are "screening themselves out of treatment because of ignorance and misunderstanding."

As part of the campaign, NAMI placed a number of educational spots about mental illness in *USA Today* to coincide with Mental Illness Awareness Week, which ran from October 6 to 12 this year. The spots featured information about several mental illnesses such as schizophrenia and depression, for instance, and referred readers to NAMI's Web site to learn more about them.

NAMI has also begun educating high school debaters, who this year are arguing for and against the following resolution: That the federal government should substantially increase public health services for mental health care in the United States *(Psychiatric News*, September 20).

NAMI is reaching the debaters through a series of articles that will be appearing in the National Forensic League's (NFL) magazine, *Rostrum*. The magazine, which reaches about 2,600 schools 10 times a year, educates students, teachers, and debate coaches about various debate topics and strategies.

The NFL is a nonprofit educational honor society established in 1925 to encourage high school students to become involved in debate and public speaking.

In the first of a series of articles that appeared in the October 1 issue of *Rostrum*, NAMI President Jim McNulty described his struggles with bipolar disorder, problems with the current mental health system, and the importance of providing mental health parity to all American employees. He also illustrated the need for better mental health care with some compelling statistics—for example, 200,000 people with mental illness live on the streets, and 250,000 are behind bars in the nation's prisons.

Birkel called NAMI's liaison with the NFL "an excellent opportunity for us to tell young people the truth about mental illness."

Educating Candidates

In addition to high school students, NAMI worked on getting political candidates up to speed on a number of issues pertaining to mental health and mental illness with its "I Vote, I Count" program.

The program seeks to educate candidates and voters alike on pressing mental health issues across the U.S. while clarifying candidates' positions on the issues.

"In this year's elections, there was a great deal of turnover in the state legislatures due to term limits and redistricting," program director Mike Fitzpatrick explained. "We saw this as a tremendous [opportunity] to educate candidates about mental health issues."

Fitzpatrick called declining state budgets and skyrocketing health care costs "a perfect storm of budget crises" that have forced candidates to confront mental health topics head on.

"Rapidly declining revenues haven't flattened out yet, and health care costs are rising at 13 percent," Fitzpatrick said. The time leading up to the November elections was opportune "for candidates to talk about how they plan to deal with the Medicaid program, medications, and funding community services."

To start a dialogue between candidates and voters, NAMI held candidate forums at 49 sites across the country on its own or with other groups, such as the League of Women Voters. At the forums, NAMI members asked prearranged questions on mental health topics.

Fitzpatrick said that there were usually about five questions about mental health issues pertaining to children and adolescents, adults, and elderly people at each forum.

In addition, NAMI created questionnaires with relevant questions on mental health for political candidates to complete. NAMI then publicized the results of the questionnaires so that voters could make a well-informed decision at the polls, according to Fitzpatrick.

NAMI leaders also hold meetings with the candidates once they get into office to continue the "education and relationship-building process," Fitzpatrick said.

Families Help Families

The Campaign for the Mind of America also involves the expansion of two of NAMI's longstanding programs. One is the Family to Family Education Program, in which families of people with mental illness come together for a free 12-week course to share their experiences, explore topics related to recovery and rehabilitation, and become advocates.

The course began in Vermont in 1991 and has since spread to 45 states. During the course, NAMI leaders teach family members the skills that will help them cope with a number of mental illnesses including schizophrenia, depression, and panic disorder.

According to Lynne Saunders, director of technical assistance for NAMI's education and support programs, "when people first join the class, many know nothing about NAMI and may for the first time be speak-

please see ***Campaign*** *on page 56*

ELECTION SECTION

P4C

ELECTION SECTION
P4C

ELECTION SECTION

P4C

ELECTION SECTION

P4C

ELECTION SECTION

P4C

ELECTION SECTION

P4C

ELECTION SECTION

P4C

ELECTION SECTION

P4C

ELECTION SECTION
P4C

ELECTION SECTION
P4C

ELECTION SECTION

P4C

ELECTION SECTION
P4C

ELECTION SECTION

P4C

ELECTION SECTION
P4C

ELECTION SECTION

P4C

ELECTION SECTION

P4C

ELECTION SECTION

P4C

ELECTION SECTION

P4C

HP--APA COMM & MKTG

P4C

HP--APA COMM & MKTG
P4C

HP--APA COMM & MKTG
P4C

HP--APA COMM & MKTG
P4C

med check

COMPILED BY JIM ROSACK

Regulatory Briefs

• The Food and Drug Administration (FDA) on November 15 granted final approval to market Abilify (aripiprazole) to partners Bristol-Myers Squibb (BMS) and Otsuka America Pharmaceuticals. Indicated for the treatment of schizophrenia, the recommended target dose is 10 mg to 15 mg. Dosing must be adjusted in patients taking other medications that induce or inhibit the cytochrome P450 substrates CYP3A4 and/or CYP2D6.

Clinical testing in more than 5,500 patients worldwide suggests the most common adverse effects are headache, nausea, vomiting, lightheadedness, somnolence, akathisia, and blurred vision. Incidence of extrapyramidal symptoms and neuromalignant syndrome (NMS) were extremely low. Two cases of possible NMS occurred during clinical trials, and the incidence of extrapyramidal symptoms was 6 percent for aripiprazole and 6 percent for placebo. A BMS spokesperson told *Psychiatric News* that the new medication should be in pharmacies about the first week of this month. Prescribing information is posted on the Web at <www.abilify.com>.

• The FDA cleared for market in October a new nicotine lozenge as an alternative to existing nicotine-replacement products to help individuals stop smoking. Made by GlaxoSmithKline, the Commit brand lozenge will be available in 72-lozenge packs of either 2 mg or 4 mg strengths. Last spring, the FDA forced off the market a nicotine lollipop, maintaining that nicotine was a drug that it had authority to regulate. Complete prescribing information is posted on the Web at <www.commitlozenge.com>.

• The FDA has required Roche Laboratories to relabel Accutane (isotretinoin), its drug for severe, recalcitrant nodular acne, to carry stronger warnings about potential psychiatric adverse effects.

The label now warns that the drug "may cause depression, psychosis, and rarely, suicidal ideation, suicide attempts, suicide, and aggressive or violent behaviors. Discontinuation of Accutane therapy may be insufficient; further evaluation may be necessary." The warning is posted on the Web at <www.fda.gov/medwatch/SAFETY/2002/accutane_deardoc_10-2002.htm>.

• The FDA also approved the first generic isotretinoin, to be produced by GenPharm Inc. of Toronto. The generic will carry identical safety labeling and be distributed under the same restrictive practices as the brand-name product.

• In regulatory action overseas, the Ministry of Health, Labor, and Welfare in Japan has ordered a Dear Doctor warning for AstraZeneca's quetiapine (Seroquel) after the ministry received 13 reports of serious side effects, including one death, since the drug's launch in that country in February 2001. Case reports involved elevated levels of blood glucose, diabetic ketoacidosis, and coma.

Research Briefs

• A small study from McGill University in Montreal reports on eight subjects taking mirtazapine (Remeron), a selective combined norepinephrine/serotonin enhancer, who developed a "norepinephrine syndrome." The syndrome presented as an "atypical mania" with dysphoria, irritability, insomnia, psychomotor agitation, and abnormal gait, which the authors hypothesize is directly related to a "central norepinephrine hyperactivity."
(Int Clin Psychopharmacol 2002; 17:319-322)

• A Spanish report warns that risperidone (Risperdal), when given in combination with the antiviral medication ritonavir (Norvir, commonly used in patients with HIV infection or AIDS), can lead to a reversible coma. Risperidone is a substrate and weak inhibitor of the cytochrome P450 enzyme, CYP2D6, and a substrate of CYP3A4. When given in combination with other drugs that inhibit one or more of those substrates (ritonavir inhibits both 2D6 and 3A4), metabolism of the drug is significantly slowed, allowing serum concentrations of risperidone to increase dangerously, producing serious side effects. The report warns physicians to reduce dosages of both drugs accordingly.
(Clin Neuropharmacol 2002; 25:251-253)

• In a large, multicenter study, researchers have reported that serious skin reactions associated with lamotrigine (Lamictal) are rare. While the rash sometimes associated with the anticonvulsant drug, which is often used as a mood stabilizer, can potentially be life threatening, the report notes, in more than 1,950 patients, the incidence of benign rash associated with the drug was 8.3 percent, and a serious skin reaction occurred in 0.1 percent of patients, with only one case of the most severe, potentially life-threatening type of reaction, Stevens-Johnson syndrome. The study was funded by Lamictal maker, GlaxoSmithKline.
(J Clin Psychiatry 2002; 63:1012-1019)

• Japanese researchers report that severe weight gain can be a serious side effect of combination therapy involving atypical antipsychotics and certain SSRIs. In particular, in a retrospective chart review, they identified the combination of risperidone and paroxetine as associated with severe weight gain—as much as 14 kg over four months in one patient—that also resulted in diabetic complications. The authors speculate that the cause is a drug-drug interaction involving inhibitory actions by both drugs on the cytochrome P450 enzyme, CYP2D6.
(Clin Neuropharmacol 2002; 25:269-271)

• A Spanish report indicates that olanzapine (Zyprexa) may be considered as a first-line treatment for severely psychotic inpatients with schizophrenia. In a sample of 483 patients treated with olanzapine compared with 421 treated with typical antipsychotics, overall improvement in symptomatology was significantly greater with olanzapine, as measured by BPRS positive and negative scores and the CGI. Zyprexa maker Eli Lilly partially funded the study.
(Int Clin Psychopharmacol 2002; 17:287-295)

• A review of the England- and Wales-based General Practice Research Database, which holds clinical records of more than 3.5 million subjects, suggests a strong association between olanzapine exposure and hyperlipidemia in patients with schizophrenia. Researchers found 1,268 cases between June 1, 1987, and September 24, 2000, and matched those with 7,598 medication-naïve control subjects with schizophrenia. Patients on olanzapine had a fivefold increase in odds of developing hyperlipidemia compared with controls, and a threefold increase compared with patients taking typical antipsychotics. Risperidone, the only other atypical studied, was not found to be associated with an increased incidence of hyperlipidemia. The study was partially funded by unrestricted funds from BMS, maker of the novel antipsychotic, aripiprazole (Abilify).
(Arch Gen Psych 2002; 59:1021-1026)

• Topiramate (Topamax) appears to effectively block SSRI-induced weight gain in patients with anxiety disorders, according to a new study. The report looked at a small cohort of 15 patients, who prior to adding topiramate to their drug regimen, had gained an average of 13 kg. After adding topiramate (at an average dose of 135 mg per day), by the end of 10 weeks the cohort had lost an average of 4.2 kg. The study was partially funded by Janssen–Ortho McNeil, maker of Topamax.
(J Clin Psychiatry 2002; 63:981-984)

• Galantamine (Reminyl), an acetylcholinesterase inhibitor commonly used in Alzheimer's disease and other dementias, may be beneficial in improving negative symptoms in patients with treatment-refractory schizophrenia. Adding galantamine at 12 mg twice a day to a patient's existing antipsychotic regimen was associated with a clinically significant improvement in negative symptoms within one week of starting the medication, according to a case report. In addition, within a few days of discontinuing the drug, negative symptoms worsened, returning to baseline. Positive symptoms were unchanged during galantamine therapy.
(Clin Neuropsychopharmacol 2002; 25:272-275)

• A report from Brookhaven National Laboratories indicates that for a drug to be associated with dopamine-driven reward and addiction, the drug must cause increases in striatal dopamine levels rapidly. Using PET imaging during drug intoxication, researchers verified a long-held hypothesis that increases in dopamine that occur more slowly do not lead to addictive potential.
(Behav Pharmacol 2002; 13:355-366)

• Researchers at Eli Lilly have produced further evidence that their new ADHD medication, atomoxetine (Strattera), works through increasing extracellular levels of norepinephrine (NE). In a study in rats, the medication was shown to have very high affinity for norepinephrine transporters, less affinity for serotonin transporters, and relatively low affinity for dopamine transporters. The high affinity for the NE transporter blocks reuptake of NE, increasing availability of the neurotransmitter in synapses in the prefrontal cortex of the rats.
(Neuropsychopharmacology 2002; 27:699-711)

Industry Briefs

• A new report from Decision Resources, an independent pharmaceutical research and advisory company, forecasts that Lilly's new antidepressant duloxetine (Cymbalta) will be the most promising drug launched between 2001 and 2011. The report projects that the new drug will make up 20 percent of all antidepressant sales by 2011. Duloxetine, a combined serotonin/norepinephrine reuptake inhibitor that is more equally balanced in its inhibition of serotonin vs. norepinephrine reuptake than venlafaxine (Wyeth's Effexor), received its approvable letter from the FDA earlier this year, and Lilly hopes to receive final marketing clearance in the first quarter of next year. The report notes that the drug's favorable safety profile is especially appealing to general practitioners who have been slow to accept venlafaxine because of its potential to cause cardiac side effects (notably, high blood pressure).

• New data on duloxetine, released by Lilly last month at the U.S. Psychiatric and Mental Health Congress, further indicate that the drug is not only safe (a 52-week, open-label study), but that patients exhibit clinically significant improvements in key mood and anxiety symptoms by the end of the first week of drug therapy, as well as improvements in all depressive symptoms by the end of the second week (two separate nine-week studies).

• Two company-funded studies presented at the recent annual meeting of the American Academy of Child and Adolescent Psychiatry find that both Concerta (McNeil Pharmaceuticals' methylphenidate) and Adderall XR (amphetamine mixed salts manufactured by Shire Pharmaceuticals Group) are effective and safe, as well as comparable to traditional multiple daily dose regimens. The Adderall study looked at nearly 3,000 children (aged 6 to 12) with ADHD, concluding that the drug was associated with significant improvements in relationships with family and friends, as well as scholastic, emotional, and physical functioning of the children. The Concerta study looked at 177 children (aged 13 to 18) with ADHD and concluded that the drug is effective and safe and not statistically significantly different from twice-daily dosing of short-acting methylphenidate. ■

professional news

Stress

continued from page 9

years of experience individuals had, the less stressed they were, and if individuals were male, they were less stressed," he said.

A possible explanation for the influence of the first of the two variables, Strasburger suggested, is that "time, education, and experience are the only real remedies" that mitigate the stress in more senior forensic psychiatrists. "What is not clear from our data," he noted, "is whether the people have been in the field for a longer time are somehow different from those who are relative novices, or whether just staying with this kind of work will, over time, lead to the expert experiencing less stress."

As for the gender factor, he noted that two questions merit further research before a theory can be offered: Do women working in a previously male-dominated field have a special vulnerability? Is the buffeting of the adversary system more severe for women than for men?

Additional research in this understudied area would, Strasburger emphasized, help AAPL "develop more specific supports, for instance for women entering the field, [and] enhance our awareness and understanding of each other and ourselves." ■

Some Women Have Reason To Worry About SAD Risk

Living in a northern latitude increases the risk for seasonal affective disorder. However, there seem to be other risk factors—being a female, a female with attention-deficit/hyperactivity disorder, or a female who has experienced postpartum depression.

BY JOAN AREHART-TREICHEL

The Canadian Rockies in November are a spectacular sight—snowy peaks burnished by a copper sun and set against an indigo sky. But for people who have a susceptibility to seasonal affective disorder (SAD), the Canadian Rockies are not a propitious place to be at this time of year, and even less so as the days grow shorter and darker.

The reason is that the mountains are located far north in the Northern Hemisphere, and the farther north people live, the greater their chances of having the disorder. One study, for instance, found the prevalence of SAD to be only 4 percent in Florida, yet 18 percent in the Canadian Arctic.

Latitude, however, does not seem to be the only risk factor for SAD. There seem to be at least three others —being a female, being a female with attention-deficit/hyperactivity disorder (ADHD), or being a female who has experienced postpartum depression.

These findings were revealed at the annual meeting of the Canadian Psychiatric Association in November in Banff, Alberta, during a session titled "New Insights Into Seasonal Depression."

Being female is a strong risk factor for SAD, both Robert Levitan, M.D., an associate professor of psychiatry at the University of Toronto, and Maria Corral, M.D., a clinical professor of psychiatry at the University of British Columbia, concurred. Some 80 percent of SAD patients are female, Levitan said.

What's more, women who have ADHD may be even more at risk of SAD than women in general, Levitan pointed out. For some eight years, while running a SAD clinic, he noted that a number of his SAD patients also had ADHD. So he suspected that there might be some connection between the two disorders. He then joined forces with colleagues at an adult ADHD clinic to do a study to see whether he could confirm his suspicion.

They gave a questionnaire to 130 ADHD patients at the clinic to determine whether they might also have SAD. Indeed, the incidence of SAD in this group turned out to be four times higher than one would expect in the general population, suggesting that SAD may have a link with ADHD.

Patients Sensitive to Environment

Such a link is perhaps not surprising, Levitan commented, since both ADHD patients and SAD patients are "very much tied to their environment"—that is, very sensitive to it.

But how might ADHD and SAD be related, since the former appears to involve a dysfunction of the neurotransmitter dopamine, whereas the latter seems to entail a malfunction in the neurotransmitter serotonin?

One possibility is that a mishap in dopamine action as well as in that of serotonin may underlie SAD, or at least those SAD cases that have an ADHD component.

For instance, Raymond Lam, M.D., of the University of British Columbia reported that he and his colleagues have found what appears to be the involvement of dopamine as well as of serotonin in a few cases of SAD. They depleted levels of dopamine in nine SAD patients and found that it made the patients depressed, even though it was summer and not the time of year when they usually got depressed. In contrast, when they gave the patients a placebo, it did not achieve the same effect. So they think that dopamine may be implicated in SAD.

Search for Gene Variant

Then Levitan and his colleagues studied 108 SAD patients to determine whether they carried a particular version of a gene that makes the so-called "D4" nerve receptor for dopamine. This particular gene variant has been strongly implicated as a susceptibility gene for ADHD. They found that a number of the patients, but not all, had this gene version. They also found that those patients who had this gene exhibited significantly more ADHD symptoms than did the patients without it. So the version of the dopamine receptor gene that underlies ADHD may also be implicated in SAD, at least in those cases of SAD that have an ADHD component.

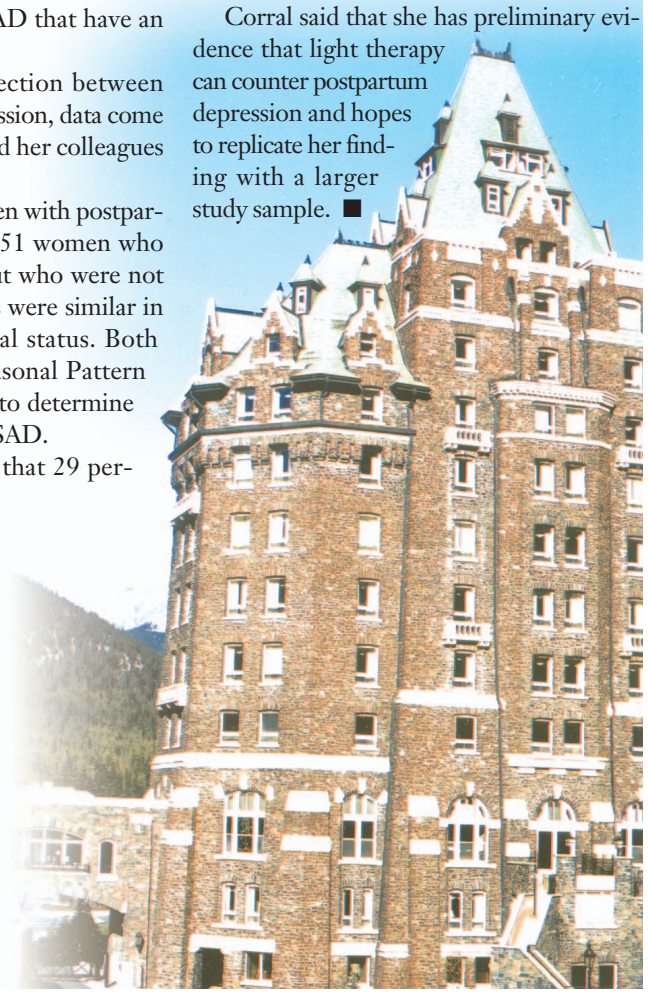
As for a possible connection between SAD and postpartum depression, data come from a study that Corral and her colleagues conducted.

They recruited 62 women with postpartum depression, as well as 51 women who had recently given birth but who were not depressed. The two groups were similar in age, education, and marital status. Both groups were given the Seasonal Pattern Assessment Questionnaire to determine whether they experienced SAD.

The researchers found that 29 percent of the postpartum depression group, but only 12 percent of the control group did—a statistically significant difference—implying that there might be a link between SAD and postpartum depression in some cases.

These results may have some clinical implications, the session speakers pointed out. For instance, if a woman has both ADHD and SAD, then perhaps a treatment known to be effective for SAD, such as light therapy, might be able to suppress her ADHD as well as her SAD. Or if a woman who experiences postpartum depression also has a susceptibility to SAD, then light therapy might also be able to counter her postpartum depression.

Corral said that she has preliminary evidence that light therapy can counter postpartum depression and hopes to replicate her finding with a larger study sample. ■



The Fairmont Banff Springs Hotel in Banff, Alberta, Canada, hosted the Canadian Psychiatric Association's 2002 annual meeting. It was most appropriate that the session on seasonal affective disorder was held in Banff since Banff is in the Canadian Rockies, and people who live in more northern latitudes such as the Canadian Rockies are more at risk of seasonal affective disorder than are persons who live in more southern latitudes.

Depression Plus Anger Prompts Search for Genetic Link

Maybe those ancient Greeks were onto something when they described certain people as having "yellow, choleric, bile types of personalities." Psychiatric researchers at Harvard Medical School and Massachusetts General Hospital are conducting studies to find out.

BY JOAN AREHART-TREICHEL

Could there be a subtype of depression characterized by irritability and anger—what the ancient Greeks called "the yellow, choleric, bile type of personality"?

Maurizio Fava, M.D., a professor of psychiatry at Harvard Medical School, thinks that there might be. In fact, a decade or so ago, he described "depression with anger attacks." Moreover, one of the young psychiatric researchers working with him—Roy Perlis, M.D., an instructor in psychiatry at Harvard Medical School—is getting a study under way to probe for a gene or genes that might underlie this kind of depression.

Roy Perlis, M.D.: "I think we may be onto genes that cross criteria in *DSM-IV*."

Perlis announced this effort at the 14th Annual Scientific Symposium of the National Alliance for Research on Schizophrenia and Depression, held in New York City in October.

So far, Perlis explained, he and his colleagues have collected DNA samples from some 150 subjects with either major depression alone or with major depression accompanied by anger attacks, and they plan on ultimately collecting such samples from 300 such individuals. They will then probe the samples to see whether they can find a gene or genes that are peculiar to major depression accompanied by anger attacks.

"I think we may be onto genes that cross criteria in *DSM-IV*," he said. "For instance, bipolar patients who are depressed often show anger."

Someone in the audience asked Perlis whether more men than women experience depression with anger outbursts, since men have higher levels of testosterone than do women and thus tend to be more aggressive. On the contrary, Perlis replied—more women than men seem to experience them. However, when men do experience depression with anger outbursts, he added, they tend to be more violent than women.

Someone else asked whether Perlis and his coworkers planned to measure the testosterone levels of their subjects. While he responded no, he said that it was a good idea.

Perlis likewise reported that he and his coworkers are collaborating with a group of researchers at Massachusetts General Hospital to investigate whether brain-imaging data might distinguish persons with major depression and anger from those with just major depression.

The type of research that Perlis and his colleagues are pursuing is similar to that being pursued by some other psychiatric investigators today, Lewis Judd, M.D., chair of psychiatry at the University of California at San Diego, pointed out at the symposium. In other words, they are attempting to identify subtypes of depression that to date have not been recognized by the psychiatric community. ■

NARSAD Gala Honors Groundbreaking Researchers

The annual gala dinner of the National Alliance for Research on Schizophrenia and Depression filled two purposes. It raised a substantial amount of money for psychiatric research and honored psychiatric investigators.

BY JOAN AREHART-TREICHEL

On October 11, something noteworthy took place in the field of psychiatric research. The National Alliance for Research on Schizophrenia and Depression (NARSAD) held its annual awards dinner in New York City.

The dinner raised more than $1.3 million for research in schizophrenia, affective disorders, and other psychiatric illnesses. Undoubtedly a substantial part of this money will be used for novel research or for studies undertaken by young investigators, as has been the case in the past (see page 46). But the dinner also honored four well-established psychiatric scientists for their outstanding research contributions.

The scientists were Francine Benes, M.D., Ph.D., a professor of psychiatry at Harvard University Medical School; Paul Grof, M.D., Ph.D., a professor of psychiatry at the University of Ottawa; Ronald Duman, Ph.D., a professor of psychiatry and pharmacology at Yale University Medical School; and Judith Rapoport, M.D., chief of the Child Psychiatry Branch at the National Institute of Mental Health.

Benes received NARSAD's 2002 Lieber Prize for Schizophrenia Research for her studies of neuronal miswiring in the brains of schizophrenia patients. The Lieber award selection committee noted that her research "helped to spawn a new era of neuropathology focused on specific circuits and neuroscience-based hypotheses of structural deficits in the brains of patients with schizophrenia."

Benes has also undertaken studies of the onset of schizophrenia. In 1996, for instance, she and her colleagues demonstrated that during late adolescence and early adulthood neurons using dopamine appear to increase their interactions with neurons that use GABA in the limbic area of the brain. She postulated that this change might trigger the start of schizophrenia in persons susceptible to the illness.

Both Grof and Duman received NARSAD's 2002 Nola Maddox Falcone Prize for Affective Disorders Research. Grof received the award for his contributions to the understanding and treatment of bipolar disorder. He has conducted pioneering studies revealing the unpredictable recurrent course of bipolar illness and the unique and complete response to lithium carbonate in a subgroup of patients. Duman got the award for helping define the neurobiological mechanisms involved in the effects of stress and antidepressant medications. For example, he and his colleagues showed that chronic antidepressant treatment blocks or reverses cell loss causes by stress—loss that is believed to contribute to depression.

At an awards ceremony in New York City in October, NARSAD recognized (from left) Paul Grof, M.D., for bipolar disorder research; Judith Rapoport, M.D., for child psychiatry studies; Francine Benes, M.D., Ph.D., for schizophrenia investigations; and Ronald Duman, Ph.D., for research on neurobiological effects of stress and antidepressant medications.

Rapoport received NARSAD's Ruane Prize for Outstanding Research in Child and Adolescent Psychiatry. According to the Ruane award selection committee, Rapoport's research "emerged during an era when it was almost inconceivable to think of children as having a psychiatric disorder. She pioneered the use of medication to help children with attention-deficit disorder, obsessive-compulsive disorder, and, most recently, with schizophrenia." For instance, she was the first to investigate atypical antipsychotic medication in children with schizophrenia.

NARSAD also presented two public service awards at the dinner. One went to Sylvia Nasar, author of the bestselling book *A Beautiful Mind*, which is the story of a brilliant mathematician who developed schizophrenia. The other award was bestowed on the team that made the Oscar-winning film based on the book. ■

Transdermal Patch Could Herald Renewed Popularity for MAOIs

Monoamine oxidase inhibitors may be poised for a comeback, thanks to a novel way of administering the often troublesome, but effective, antidepressants.

BY JIM ROSACK

Administering the selective monoamine oxidase inhibitor (MAOI) selegiline through a transdermal patch could be an effective and safe alternative in antidepressant therapy, if early research is replicated.

J. Alexander Bodkin, M.D., an assistant professor of psychiatry at Harvard Medical School and research psychiatrist at McLean Hospital, reported in the November *American Journal of Psychiatry* that transdermal selegiline at a dose equivalent to 20 mg per day was an effective and well-tolerated antidepressant therapy.

The study reported, the first of four clinical trials involving the transdermal patch, was funded by Somerset Pharmaceuticals, which is developing the product under the trade name EmSam. An application in May 2001 to the Food and Drug Administration for approval of the transdermal product was ultimately deemed by the FDA to be not approvable. Company officials hope to reapply in the first half of next year with more complete efficacy and safety data, a company source said.

An Efficacious Alternative

Bodkin and Jay Alexander, M.D., director of the Depression Research Unit at the University of Pennsylvania School of Medicine, compared 177 adult outpatients with major depression, randomly assigning 89 to receive the active selegiline patch, and 88 randomly assigned to receive a placebo patch. After a one-week washout during which all subjects wore a placebo patch, the subjects completed a six-week blinded comparison. All subjects followed dietary restrictions commonly used when taking MAO inhibitors.

Response to medication or placebo was primarily gauged by the 17-item Hamilton Depression Rating Scale (HamD), with the Montgomery-Asberg Depression Rating Scale, and the Clinical Global Impression (CGI) severity and improvement subscales as additional outcome measures.

At the end of the six weeks, patients wearing the selegiline patch saw greater improvement on all measures compared with placebo. Average scores on the HamD improved by 38 percent for those on selegiline versus 26 percent for those on placebo. A similar difference was seen in the Montgomery-Asberg ratings, with a 34 percent reduction for subjects taking selegiline and a 19 percent reduction for those on placebo. Thirty-seven percent of those on selegiline achieved remission, characterized by a 50 percent reduction in their HamD score or a final HamD score below 8, compared with 22 percent on placebo. In addition, 42 percent of those wearing the selegiline patch were rated as "much improved" or "better" on the CGI compared with 27 percent of those wearing the placebo patch.

Safety Addressed

MAO inhibitors have generally been considered to have robust efficacy in depression, especially in cases of atypical or treatment-resistant depression. Their use has been severely limited, however, by adverse effects tied to interactions with enzymes in the gastrointestinal tract.

The MAO family of enzymes are found throughout the body, with high concentrations in the liver, kidney, stomach, intestinal wall, and brain. They are generally broken down into two types, MAO-A and MAO-B. Type A is predominantly found in the gastrointestinal tract, while type B is predominant in brain tissues. Both types are responsible for the breakdown of catecholamines, including dopamine, epinephrine, norepinephrine, and serotonin in brain tissues.

In the GI tract, MAO is responsible for breaking down amines absorbed through dietary intake. When the process is inhibited in the GI tract, potentially high amounts of amines—in particular dietary tyramine, found in most cheeses, beer, wine, and many vegetables and fruits—can be absorbed.

High blood levels of these amines can lead to hypertensive crisis, stroke, and heart attack and can be fatal.

Administering an MAO through a transdermal patch offers several benefits. First, according to Bodkin, lower doses of the drug are required because bypassing the GI tract allows the drug to be absorbed directly into the blood without undergoing "first-pass metabolism," the initial metabolism of the drug as it is processed in the liver after absorption.

Second, in the case of selegiline, at lower doses, Bodkin said, the drug is a fairly selective MAO-B inhibitor. As such, the MAO-A necessary for dietary amine control is not affected, greatly reducing the risk of hypertensive adverse effects.

In the present study, the only common significant side effect was a local skin irritation or reaction at the site of application of the selegiline patch (36 percent of those with selegiline compared with 17 percent wearing placebo). Notably, no subjects experienced any clinically significant elevations of blood pressure.

"So, now we have a way of getting an MAO inhibitor antidepressant to the brain without interfering with the MAO in the digestive system," Bodkin said in a press release. "Close to 20 percent of treated patients with depression do not do as well as they could. With selegiline in patch form, there will be a significant number of people who can get much better."

The article "Transdermal Selegiline in Major Depression" is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/159/11/1869>. ■

Living Long and Alzheimer's Free Linked to Genes, MH History

What does it take to arrive at one's golden years with a sound mind? Although all the answers are not in, several involve having the right genetic makeup and enjoying mental health in one's younger years.

BY JOAN AREHART-TREICHEL

What are people's chances of reaching a ripe old age without Alzheimer's? Probably pretty good if they have no mental disorders in their youth and younger adulthood. Probably pretty good if they don't carry the "e4" version of apolipoprotein-E. And probably pretty good if they carry a particular version of a gene on the male sex chromosome.

So, at least, suggests a study of 100 elderly subjects and of 100 younger ones in one of the senior pockets of the United States—southwestern Pennsylvania. The study was conducted by George Zubenko, M.D., Ph.D., a professor of psychiatry at the University of Pittsburgh School of Medicine, and colleagues and is reported in the October *American Journal of Geriatric Psychiatry*.

During the past several decades, the American population has grown older, and nowhere in the United States are there more seniors than in Florida, followed by West Virginia and Pennsylvania, especially the southwestern corner of Pennsylvania. Thus, Zubenko and his colleagues were in a prime position to tap many seniors for their study.

They advertised for seniors willing to take part in their study at primary care practices, assisted-living facilities, religious groups, community groups, and some other sources. Eventually they recruited 100 seniors—50 women and 50 men—who had reached the age of 90 years or more with a sound mind. They also recruited 100 adults who were between the ages of 18 and 25 years and matched these senior subjects on gender, race, and ethnicity.

Zubenko and his coworkers then obtained information about the mental and physical health of their subjects, as well as about personal habits that might have impacted their health and longevity. Blood samples for DNA analysis were drawn. In addition, the researchers collected DNA samples from 100 persons who had died and had been confirmed through autopsy to have had Alzheimer's disease.

Zubenko and his colleagues first compared the information they had collected about their older and younger subjects in hopes of identifying some characteristics typical of the former, but not of the latter, that might help explain how the older subjects had managed to reach 90 years with a sound mind. The researchers found one characteristic that seemed to fill the bill: not having mental disorders in one's younger years.

Specifically, the seniors in their study had experienced only half the lifetime prevalence of mental disorders that the young subjects in their study had, even though the younger subjects had not lived through the age of risk for developing most mental disorders. All of the mental disorders experienced by the elders developed in late life, that is, after 81 years of age. Other studies showed that having mental disorders early in life can thwart longevity. Thus, not having had mental disorders in their earlier years may have helped these seniors reach old age cognitively intact, Zubenko and his coworkers reasoned.

Second, Zubenko and his team used the DNA samples that they had collected from their senior subjects and from their junior subjects, as well as from the 100 persons who had had Alzheimer's disease before dying to determine how common the e4 version of apolipoprotein-E was in each of the three groups. They were interested in the e4 version since it has been linked with susceptibility to late-onset Alzheimer's (*Psychiatric News*, October 4). They found that 42 percent of the deceased persons with Alzheimer's and 12 percent of the young adults had the e4 version, compared with only 7 percent of the seniors. Thus, not having this e4 version probably also helped their seniors make it to age 90 with a sound mind, Zubenko and his colleagues think.

Finally, Zubenko and his coworkers compared Y chromosomal material from their male senior subjects to Y chromosomal material from their male younger subjects in hopes of identifying one or more differences. And indeed, they found a particular region on the Y chromosome that differed significantly between the two groups of subjects. Thus, they suspect that a particular version of a gene in this region of the Y chromosome might have helped their male seniors make it to age 90 with a sound mind.

The study was funded by the National Institute of Mental Health.

The study, "Genome Survey for Loci That Influence Successful Aging," is posted on the Web at <http://ajgp.psychiatryonline.org/cgi/content/full/10/5/619>. ■

LILLY ZYPREXA
P4C

Brain-Activation Patterns Change In Youngsters With Bipolar Disorder

Researchers visualize the brain activity of youngsters with bipolar disorder to see how it affects that activity over time. Preliminary results suggest that the disorder progressively impairs certain brain areas, while activating others.

BY JOAN AREHART-TREICHEL

What does bipolar disorder do to the brain activity of children? Melissa DelBello, M.D., an assistant professor of psychiatry and pediatrics at the University of Cincinnati, and her colleagues are trying to find out.

And their very preliminary results—results that may change as data from more subjects are analyzed—suggest that the disorder progressively impairs certain brain areas, yet at the same time activates other brain areas, probably in compensation.

DelBello described her study and the preliminary results at the 14th Annual Scientific Symposium of the National Alliance for Research on Schizophrenia and Depression (NARSAD), held in New York City in October. NARSAD showcased some of its most promising younger scientists, such as DelBello, at this symposium.

DelBello and colleagues recruited 12 youngsters with first-episode bipolar disorder and 12 youngsters with multiple-episode bipolar disorder to serve as subjects. They wanted only multiple-episode patients who were completely noncompliant with their medications, so medications could not compromise their study results.

They found their subjects at their university hospital. They also enrolled 12 healthy youngsters of the same age, gender, socioeconomic status, and handedness to serve as controls.

Then came the task of getting their young subjects into a functional magnetic resonance imaging (fMRI) machine. Actually it wasn't so difficult, DelBello said, since she and her coworkers explained to the young people that it would be like entering a spaceship. But then came the greater challenge of getting the children to hold still, both while they were engaged in a resting task and in a performance task.

The resting task consisted of looking at numbers flashing on a screen. The performance task consisted of pushing a button when they saw the same number flashed twice on a screen. The scientists took a fMRI scan of the brain of each child while the child was engaged in each task.

The researchers then compared fMRI scan results for each subject—that is, from when the subject was simply viewing numbers to when he or she was pressing a button while viewing numbers—to discern which brain areas were activated during the latter period. They then compared brain activation for each subject with brain activation of other subjects in this group. Finally, they compared brain activation of one group with that of the other two groups.

As of now, DelBello and her team have brain activation results for 12 subjects in the control group, 10 in the first-episode group, and six in the multiple-episode group.

These preliminary results reveal less brain activation in prefrontal brain regions and striatal regions such as the basal ganglia of first-episode patients compared with control subjects. These results thus suggest that the prefrontal brain regions and the striatal regions are affected by bipolar disorder.

The findings likewise reveal even less activation in the prefrontal brain regions and striatal regions of multiple-episode subjects compared with first-episode subjects. These findings thus imply that the prefrontal brain regions and striatal regions are increasingly damaged as bipolar disorder takes its toll on the brain.

Interestingly, however, when the brain activation results of multiple-episode subjects are compared with those of first-episode subjects, there is even more activation in the temporal lobes and parietal lobes in the multiple-episode subjects than in the first-episode subjects. "So maybe the multiple-episode subjects are using these brain areas to compensate for those brain areas that have been compromised by bipolar disorder," DelBello speculated.

In any event, she stressed, these are very preliminary results that may change as fMRI data from all 36 subjects are analyzed. Also, she pointed out, she and her colleagues are going to follow the brain activity of their first-episode subjects over time to see whether bipolar disorder impacts their brains in the same ways that it has those of the multiple-episode patients.

"This is a beautifully designed clinical study," Lewis Judd, M.D., chair of psychiatry at the University of California at San Diego, declared at the NARSAD symposium. By using first-episode and multiple-episode patients to find out how bipolar illness alters children's brains over time, he explained, DelBello and her team are getting much quicker results than if they had simply followed the fates of first-episode patients over time.

Psychiatric News asked DelBello what implications her findings have for psychiatrists. "As we understand the brain changes that occur at onset in children with bipolar disorder and that occur over time," she said, "then we can start to see whether medications can alter these changes." ■

FOREST LEXAPRO
P4C

FOREST LEXAPRO
P4C

FOREST LEXAPRO
P4C

FOREST LEXAPRO
P4C

FOREST LEXAPRO
P4C

FOREST LEXAPRO
P4C

FOREST LEXAPRO
P4C

FOREST LEXAPRO
P4C

Transitioning Into the Post-Residency Period

BY DINU GANGURE, M.D.

The Residents' Committee of the New York County District Branch and the Residency Training Program in Psychiatry at St. Luke's-Roosevelt Hospital Center demonstrated the power of collaboration between APA's newest members at the district branch level and a training institution. The two groups recently partnered to create a program to prepare residents for the transition from residency into practice.

More than 100 trainees from hospitals throughout the New York area and beyond gathered at the Roosevelt Hospital in Manhattan on an October evening. Some came from as far away as Ohio and Washington, D.C.

The first speaker was Patrick Molloy from Molloy and Co. Management and Planning Consultants. Molloy touched upon the advantages and disadvantages of different career paths, such as solo private practice, group private practice, employment within a hospital, independent contracting with hospitals, and academic positions. He delineated the specific steps involved in pursuing each choice and their relative importance, and shared pointers for evaluating an employment contract.

The speaker also addressed items that many early career psychiatrists often neglect in their rush to establish a career: malpractice insurance, disability insurance, and certain fringe benefits. Among the tips he shared was that it is important to know whether potential employers will provide a guaranteed income as opposed to an income dependent on collections. Also, it's a good idea to meet as many people as you can when you interview for a job; many times they provide the most useful hints about "real life" in the new place. Some questions to ask: What is the patient population? What is the average caseload? How many sites will you need to cover? What kind of liability insurance will you have—claims made or occurrence? Is there a restrictive covenant in the contract? One of the greatest dangers of a restrictive covenant is that it could eventually prevent you from working in the area where you wish to practice. One possible alternative is to join the practice with a grace period of three to six months before the restrictive covenant is enforced. This arrangement enables you to get to know the group and still have choices before the restrictive covenant takes effect.

Andrew Koerner, first vice president of investments for Salomon Smith Barney's Senior Consulting Group Associates, motivated the residents to start thinking about investment planning and calculating their financial status and goals in the first five years after residency. While some early career psychiatrists are debt free, others are facing debts approaching $250,000. Regardless of debt status, however, Koerner advised that residents consider their risk style: Do they want to take an aggressive approach to maximize the benefits with a higher calculated risk or a more moderate approach to reduce the risk and increase the likelihood of obtaining at least moderate benefits?

Carl Shusterman, an attorney and certified specialist in immigration and nationality law, was the biggest attraction for many residents in the audience. Many psychiatry residents in the New York area—30 percent to 40 percent according to some reports—are international medical graduates (IMGs). They need information on how to handle the issues specific to their immigration status while in the United States. In the post–September 11 climate, changes in the rules and regulations of the Immigration and Naturalization Service are sometimes hard to keep up with, but Shusterman's Web site at <www.shusterman.com> and an e-newsletter that goes to thousands of subscribers are very helpful. Among the topics he covered were J-1 visa waivers, H1-B visas, RIR labor certifications, and National Interest waivers.

When the speakers concluded their presentations, the residents had an opportunity to ask questions. The length of this part of the evening proved the program's value—it lasted about 90 minutes and could have gone on longer: A small crowd followed one of the speakers to his limousine to throw a few more questions at him.

What have we learned from this educational experience? First of all, we have confirmed a hypothesis. While residents are eager to attend seminars on clinical topics, they also have a great need for programs on practical issues, such as launching a career after residency.

The reason that this program had an excellent attendance could be because it represented a "change in gears" in terms of topic. While residents get outstanding clinical training during their residency, few of us get direct and top-flight professional advice on how to handle the practical aspects of life after residency. There could be a considerable difference between the safe, protected environment that many training facilities offer and the free-market world that follows. Based on our experience at this Annual Speakers' Night, we encourage other district branches

please see ***Residents' Forum*** *on page 57*

Dr. Gangure is co-chair of the Residents' Committee of the New York County District Branch. He is also a senior resident in psychiatry at St. Luke's-Roosevelt Hospital Center in New York City.

letters to the editor

Psychiatric Revolutions

The article about Robert Cancro, M.D., in the September 6 issue describes two revolutions in psychiatry: the psychoanalytic in the 1950s and the psychopharmacologic in the 1960s. Each made significant contributions to psychiatry, and each became synonymous with psychiatry itself. While praising their achievements, he acknowledged their limits as treatment: "We are producing more patients than cures." Dr. Cancro would like to see a reconciliation of the two camps of zealous practitioners. Psychiatric treatment was losing the battle with mental illness.

In the decades before 1950, as psychoanalysis was being introduced throughout the world and offered the possibility of treatment for mental illness, another treatment emerged.

Chemical convulsive treatments were shown to be an effective treatment for mental illness and applauded in the press, while medical authorities called it too horrible to use. ECT soon followed; it was much easier to use and was widely overused. In the 1950s medical modification had made it safe and removed the "shocking" aspects. The real revolution in psychiatry was that psychiatry had an effective treatment for the psychoses (serious mental illness).

Psychopharmacology reintroduced the chemical treatment of mental illness with many significant improvements, but still produced more patients than cures. ECT practitioners had learned that psychoses are chronic recurring conditions and that remissions must be maintained by one or more modalities. Authoritative experts assert that ECT is underused (medication trials are overused), including the Surgeon General; Max Fink, M.D., in his 1999 book *Electroshock: Restoring the Mind;* and Sally Satel, M.D., in her 2000 book *PC, M.D.: How Political Correctnesss Is Corrupting Medicine*.

Psychiatry is indebted to psychoanalysis for the impending revolution in medical education.

Some universities have already incorporated the psychosocial model into medical education, and others are adopting it. An understanding and awareness of mental illness, psychodynamics, and emotional factors in illness is imparted to all medical students. This revolution is seen as a step toward Dr. Cancro's goal of preventing mental illness, by producing better doctors and better care.

LEWIS T. RAY, M.D.
San Francisco, Calif.

Grandparent Role

I enjoyed David Milne's article in the November 1 issue headed "Changing Your Mind May Change Your Body," which reported on Dr. Oakley S. Ray's recent talk at the XII World Congress of Psychiatry.

Although scientific studies are hard to come by to describe this phenomenon, readers need go no further than to observe the grandparent-grandchild relationship. I have been studying this bond since 1970 and have seen this phenomenon almost universally. I explained my finding in a book I wrote in 1986, *Spirit*, describing this "spiritual illumination" and "physical transformation" that often lead to increased mental and physical vitality in grandparents and joy in their grandchildren. I presented these findings at two APA meetings and have written five books on the topic. The latest is *The Grandparent Guide*.

Regrettably, the helping professions are slow to understand the importance of these roles and to capitalize on the biopsychosocial benefits of grandparenting for adults and the biopsychosocial benefits to the child who revels in being a grandchild. I have used grandparents as family historians, clinical allies, and discharge resources in my practice. I have also witnessed some remarkable transformations in, for example, grandparents who are raising their grandchildren. Interested readers may go to my Web site at <www.grandparenting.org> for more information.

ARTHUR KORNHABER, M.D.
Ojai, Calif.

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.

community news

Campaign

continued from page 18

ing publicly about mental illness."

Toward the end of the course, however, the pupils learn to become fledgling advocates. NAMI leaders teach family members about advocacy initiatives in the local area and encourage family members to become involved. Many do, by joining letter-writing campaigns, telling their stories through the media, or supporting mental health legislation at the local, state, and national levels, according to Saunders.

NAMI will also be expanding its program, "In Our Own Voice: Living With Mental Illness." Based on the premise that experience is the best teacher, the program is led by people with mental illness in various stages of recovery.

For example, program leaders may talk about their first psychotic break and first hospitalization, according to Project Director Sara Yankalunas. Treatment strategies, hopes, dreams, and successes are also likely topics for discussion. Since the program's inception in 1996, leaders have educated law enforcement officers, teachers, politicians, and general audiences about mental illness.

More information about NAMI's Campaign for the Mind of America is posted on the Web at <www.nami.org/pressroom/20021007.html>. ■

Clozaril

continued from page 2

on and whether the data were further confounded by use of multiple other psychiatric drugs in most subjects.

Suicide Probability Reduced

The study outcomes were significant. Over the two-year study period, the probability of a significant suicide attempt or hospitalization to prevent suicide was lower with Clozaril (24 percent) than olanzapine (32 percent). Those findings translate into patients being treated with Clozaril having a 24 percent lower risk of suicide attempt or hospitalization to prevent suicide compared with olanzapine-treated patients.

During the PDAC's discussion, some members felt that the agency's methodological concerns were "appropriate and valid."

Yet members noted that one of the most "startling findings" of the study was that Clozaril's effect on suicidal behaviors appears to be independent of the overall severity of the patient's symptoms. Ratings scores on the PANSS and CGI as well as other measures were not significantly different between the patients taking Clozaril and those taking olanzapine. PDAC members said that indicates that the reduction in suicide is independent of the patient's general improvement.

A New Clinical Standard

"Given the seriousness of such behavior, we clearly need specific treatments," noted Dilip V. Jeste, M.D., the Estelle and Edgar Levi Chair in Aging and a professor of psychiatry and neurosciences at the University of California at San Diego.

"While drugs alone will not treat suicidal behavior," Jeste told *Psychiatric News*, "and must be combined with psychosocial interventions, there is growing evidence to suggest some biological basis for suicidal behavior."

Steven Potkin, M.D., a professor of psychiatry at the University of California, Irvine, and a clinical investigator in the study, hailed the committee's vote. "The InterSePT study suggests that clozapine should be a first-line treatment consideration in acutely suicidal patients with schizophrenia regardless of their stage of illness and should not be limited to treatment of refractory patients. Its conclusions should offer new hope to suicidal schizophrenia patients."

Potkin said the results are especially significant because the study's methods closely mirrored real-world conditions of treatment for patients with schizophrenia. "Given the nearly 3 million patients in the United States with schizophrenia and schizoaffective disorder, and a 9 percent suicide rate, as many as 60,000 lives may be saved by treatment with clozapine," Potkin told *Psychiatric News*.

An FDA spokesperson indicated no clear timetable for final approval of the application; however, a Novartis spokesperson noted that the company is hopeful that an approval letter would be received in the first quarter of 2003.

Documents pertaining to the application and pending approval of Clozaril to treat suicidal behavior, including proposed final labeling, are posted on the FDA's Web site at <www.fda.gov/ohrms/dockets/ac/cder02.htm>. ■

residents' forum

continued from page 55

and residency programs throughout the country to fill this educational gap by offering similar events to their trainees.

One final note: the New York County District Branch is sponsoring a workshop on the same topic as this column—"Transition Into the Post-Residency Period"—at APA's 2003 annual meeting in San Francisco. We hope you will attend—it will be a good reason to attend the next annual meeting and just one of many sessions planned specifically for psychiatry residents.

If you would like advice on how to organize a program for residents transitioning out of training, please contact me by e-mail at dgangure@hotmail.com. ■

AACAP

continued from page 8

however, that the dearth of child and adolescent psychiatry faculty at medical schools creates a vacuum in which stigmatizing stereotypes about the profession flourish.

Delayed Gratification an Issue

The steering committee reported in the strategic plan that 75 percent of general psychiatry residents who plan to train in child and adolescent psychiatry don't follow through.

The vast majority of child psychiatry programs require two years of training after the completion of general psychiatry training, which usually runs three to four years, said Anders.

"General psychiatry residents headed for child psychiatry training may consider this sequence too long and expensive. They may become more interested in other adult subspecialties, including geriatrics and forensics," said Anders.

The minority medical student focus group reported that their peers are less likely to enter child psychiatry training because they have to wait so long to work with children, which is less gratifying than if they were to have contact with them early on.

Alternatives Proposed

The AACAP plan proposes several alternatives to the traditional training program that may appeal to a broad range of medical students and physicians, said Anders. These include the following:

- A four-year program focused on child and adolescent psychiatry without adult psychiatry training. This option may appeal to family practitioners and pediatricians who want to be eligible only for the child psychiatry board exam.
- A four- or five-year program integrating child and adult psychiatry training that would expose residents to child training sooner and would result in eligibility for adult and child psychiatry board certification.
- A six-year program also integrating child and adult psychiatry with an additional year for research in child psychiatry to prepare residents for academic careers.

James Leckman, M.D., chair of the AACAP Task Force on Training and Education, is developing the curricula for the integrated child and adolescent psychiatry training programs. The first year is an internship in pediatrics and neurology focusing on children and developmental issues, Leckman said at the AACAP meeting.

"The second year is designed to teach residents basic skills derived from the latest science such as using practice parameters, neuroimaging techniques with children, and conducting clinical trials," said Leckman.

Child and adult psychiatry training would be integrated into the third and fourth years. The fifth year would involve specialized electives with children, adults or families, Leckman noted.

He is seeking medical schools to pilot the proposed curricula to determine their effectiveness and residents' career satisfaction, according to Anders.

Funding Initiative Crucial

The third initiative in the plan calls for advocacy strategies to increase the reimbursement rates for child psychiatry treatment and for legislation to ease the financial burden on child psychiatry trainees and training programs, said Anders.

Retaining child psychiatrists is as important as recruitment and is linked to adequate reimbursement rates, said Gregory Fritz, co-chair of the Steering Committee on Work Force Issues, in an interview. "We lose more child psychiatrists to adult psychiatry because [adult psychiatrists] are paid the same amount of money for diagnostic evaluations that are less complex and time intensive" than ones for children.

"Our members in Massachusetts worked with Magellan this past year to obtain significant increases in child psychiatry evaluation rates. We are urging our members in their regional organizations to use the Massachusetts experience as a model to achieve similar adequate reimbursement rates throughout the country," said Anders.

AACAP's strategic plan, "Call to Action: Children Need Our Help," is posted on the Web at <www.aacap.org> with a link to the document. ■

Privacy Rule

continued from page 10

Beside patients and physicians, politicians are another group for whom medical privacy is sacred. "The November elections [were] the last in which candidates' medical information won't play a prominent role," Pyles said. He pointed out that in past elections, the American public learned of candidates' treatment for mental disorders and substance abuse, "and that was when protections were in place—now that these protections are gone, candidates' medical records are wide open" and could be campaign fodder.

Two major efforts are under way to challenge the federal medical privacy rule, Blevins explained. One is in the form of a bill, Stop Taking Our Health Privacy Act of 2002 (HR 5646). It seeks to restore patient consent to the privacy rule and expand privacy protections for patients. The bill's author is Rep. Edward Markey (D-Mass.).

Blevins also cited an effort to challenge the constitutionality of the medical privacy rule in the courts, but could offer little information about this initiative since it is ongoing.

Americans can take matters into their own hands, she added, by writing letters to Congress objecting to the removal of patient consent from the final medical privacy rule.

"Citizens don't have to accept this rule and its invasion of our medical privacy," Blevins said.

Additional information on the privacy rule is posted on the Web at <http://cms.hhs.gov/hipaa>. ■

JANSSEN RISPERDAL

P4C

JANSSEN RISPERDAL
P4C

JANSSEN RISPERDAL

P4C

continued from page 3

candidate would set the same priorities for the use of APA resources; what are yours?

Candidates differ on all of these dimensions and others. Given this diversity of traits, whom we choose to lead us makes an enormous difference.

Perhaps members care about these differences, but are frustrated by the lack of information they have about candidates. Unlike in national or even local elections, where persons running for office become familiar faces on our television sets, their records dissected and their every pronouncement parsed, the majority of members have little contact with APA candidates. To be sure, their pictures and statements appear in *Psychiatric News*—as they do in this issue—and most candidates these days have Web sites where they post additional information. But there tends to be a sameness to candidates' statements (when was the last time you saw a candidate for APA office declare support for managed care and psychologist prescribing?), and it is often hard to judge from their written words alone what kind of leaders they would be.

There are, of course, many ways to find out more about the candidates for national APA office. Every candidate lists contact information on the APA Web site and on their sites. Members can e-mail, write, or call them to find out what they think about the issues that are of importance to them. Or they could talk to APA members who know the candidates, including their Assembly representatives and people who come from the candidates' parts of the country. Since many officer candidates travel around the country to subspecialty and district branch meetings, a good number of members will have the opportunity to meet them and size them up face to face. Of course, seeking information in this way takes some effort—it is not quite as simple as watching advertisements during breaks in a football game. But the returns in being able to cast a meaningful vote are substantial.

I have not canvassed the full panoply of possibilities for the low turnout in our elections. I understand that Americans as a nation are withdrawing from involvement in organized activities, preferring, as sociologist Robert Putnam would put it, to "bowl alone." But I doubt that same phenomenon accounts for the diminishing interest in APA elections. Ballots go out only to APA members—those psychiatrists who have chosen to join together to fight for our common interests and to derive the benefits of a professional association. One might think, therefore, that they would be particularly likely to participate actively in selecting their leaders. That fewer than one-third do so is perplexing, but it must relate to something more than just a generalized withdrawal from social intercourse.

If you think other factors are involved, please write me and let me know. Moreover, if you have thoughts about what we should do about it, I'd like to hear that too. Some professional organizations don't hold contested elections, at least for their highest offices. Others limit campaigning much more than we do. Would these changes help? Or is there something else that would make a difference?

Meanwhile, we've got an election to run. This year, your vote is particularly important. On the ballot are Bylaws changes that would reduce the size of the Board of Trustees by two positions, roughly 10 percent of the voting members. The changes, approved by the Board, are an effort to improve the Board's functioning and to reduce its cost. I suspect an overwhelming number of members would approve of this initiative. But unless at least one-third of members cast ballots, the amendment will fail—even if all of those voting support the measure.

So when that ballot comes, please vote. Vote by paper ballot or, if it's easier, vote on the Internet (if you do, you save APA the cost of receiving and processing your ballot). I'm tempted to urge you to vote early and often—but let's save that for another time. This year, just vote. Please. ■

legal news

FBI

continued from page 16

So sometimes to identify smart or tricky criminals, "we try to lay traps of behavior," McCrary said.

For instance, agents may use the "Columbo" trick—that is, the trick that television police detective Columbo used to use: He would intentionally appear stupid and bumbling to reinforce a transgressor's sense of omnipotence and thus get the offender to divulge his identity. The FBI, in fact, used this trick recently in the Washington, D.C., sniper case, McCrary pointed out. It attempted to make the Montgomery County, Md., police chief look inept and frazzled, and this apparent incompetency helped reinforce the narcissism of the purported offenders and led to their identification and capture.

Or knowing that murderers sometimes visit the graves of people they have killed, FBI agents may use this information to trap them. For example, there was a father whom FBI agents suspected of killing his son. So they sent one of their agents in disguise to the father; the agent told the father that he was going to the grave site where the son was buried and asked whether he wanted to come along. The father said yes. And while at the grave site, the father broke down and admitted to killing his son—just the confession the FBI agents had hoped for.

And once FBI agents have a suspect in hand, McCrary explained, they may even use information they have about the criminal's psyche and behavior to get the person to confess. For example, say FBI agents want to trick a rapist, who they know despises women, to confess. They might send a "bossy" female FBI agent in to interview and antagonize him. Then, after the female agent walks out, a male FBI agent might enter the room to calm him down, establish a rapport with him, and then elicit a confession. ■

Commission

continued from page 1

"None of us [commissioners] was surprised by the problems. But we were surprised by their scope and complexity."

(See article below for comments by Anil Godbole, M.D., one of the commission's three psychiatrists.)

According to the interim report, "The commission is united in the belief that the mental health service delivery system needs dramatic reform. It is becoming clear that the mental health service system does not adequately serve millions of people who need care."

Hogan added, "A parent seeking treatment for his child told us, 'The system is opaque.' "

He noted that the last presidential commission on mental health, which was appointed by Jimmy Carter, issued its report in 1978.

Some of the measures designed to address problems outlined in that report "made things worse," according to Hogan.

The interim report asserts, "Many of the problems are due to the 'layering on' of multiple, well-intentioned programs without overall direction, coordination, or consistency. The system's failings lead to unnecessary and costly disability, homelessness, school failure, and incarceration."

Hogan described other structural problems. "The big money for mental health services comes from the federal government, but responsibility for administration is at the state and local levels."

Medicaid has become the primary source of public funds for mental health services, but that program was not designed to provide those services, he told the audience.

"Much that is positive has happened since the last presidential commission," Hogan said. "Then, doctors had hunches about what might work. Since then, we've developed effective treatments."

He added, however, that half of all people who need treatment do not receive it. The rate is even lower for racial and ethnic minorities, and the quality of care they receive is poorer.

Barriers to Care

The presidential commission identified five barriers that impede access to care—fragmentation and gaps in care for children, fragmentation and gaps in care for adults with serious mental illness, high unemployment and disability for people with serious mental illness, lack of care for older adults with mental illness, and failure to establish mental health and suicide prevention as national priorities.

In the interim report, the description of each barrier is followed by an account of a community-based program that successfully addresses the problems associated with the barrier.

APA Vice President Steven Sharfstein, M.D., will chair a new task force to develop a vision statement outlining a vital and well-functioning mental health system.

At the press conference, Hogan focused on the prevalence and cost of high unemployment for people with serious mental illness.

People with mental illness are the largest and fastest growing group of people with disabilities receiving Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) payments. An estimated $25 billion is spent annually for those payments, but the benefits still are not adequate to secure safe housing.

In addition, SSI and SSDI benefits are linked to eligibility for health care coverage under Medicaid. Many people with a mental illness find that they cannot afford to go back to work because they would lose their Medicaid coverage.

According to the report, "Thousands of people with a mental illness make a conscious choice to stay on disability assistance because it provides Medicaid coverage for their expensive medication and treatment needs."

APA to Offer Alternative Vision

In his press release, Appelbaum announced his appointment of a Board of Trustees task force that will develop a model of what a vital and well-functioning mental health system should look like.

APA Vice President Steven Sharfstein, M.D., the task force chair, told *Psychiatric News*, "We will be looking at the problems in light of psychiatric values and ethics with the aim of describing what we would want for the organization and delivery of mental health services."

Sharfstein shares Appelbaum's concern about the commission's failure to acknowledge the "systematic defunding of mental health services."

"In 1978," he said, "at the time of the last report on mental health by a presidential commission, 8 percent to 9 percent of the health care dollar went to mental health services. Now it is between 2 percent and 3 percent."

Go Beyond Cost Neutrality

Sharfstein thinks that commission members should make a broader interpretation of its mandate to provide cost-neutral solutions. "They should consider, for example, the costs to the criminal justice system of inadequate funding for mental health."

He noted the blurring of lines between the public and private sectors and that cost-shifting occurs between them.

"Medicare and Medicaid are critical for financing treatment, and the commission should take a serious look at how some of their policies pose barriers to care from the private sector," he said.

Members of the APA task force are Norman Clemens, M.D., David Fassler, M.D., Michelle Riba, M.D., Susan Padrino, M.D., and Roger Peele, M.D.

They plan to issue their report by May 2003, when the New Freedom Commission issues its final report.

On November 12, APA President-elect Marcia Goin, M.D., had an opportunity to urge the commission to broaden its scope and consider the financial and social costs of the crisis in access when she met with Hogan and three other commission members in Los Angeles.

She told *Psychiatric News*, "I described the problem in Los Angeles County, which has a population of 10 million and only 230 psychiatric beds for the uninsured. Emergency rooms are overwhelmed. I also was able to describe similar problems in other states because of information provided by APA's Assembly."

Commission members had visited the Los Angeles County Jail, which offers "an exemplary mental health treatment program." "But," Goin told the group, "people with serious mental illness and substance abuse disorders are filling the jail system because treatment is not available for them through the mental health system."

She argued that dollars directed to the mental health system should, in the long run, result in savings in criminal justice cost.

Goin urged APA members to post comments about the crisis in access on the public comments page of the commission's Web site and to send her a copy. The addresses are <www.mentalhealthcommission.gov/comments.html> and mgoin@hsc.usc.edu.

The New Freedom Commission on Mental Health was established by executive order on April 29. Bush asked the commission to recommend improvements in the U.S. mental health service system for adults with serious mental illness and for children with serious emotional disturbances.

He requested a review of both public and private sectors to identify policies that could be implemented by federal, state, and local governments to maximize the usefulness of existing resources, improve coordination of treatments and services, and promote a full life in the community for people with mental illness.

The interim report and minutes of meetings of the New Freedom Commission on Mental Health are posted on the Web at <www.MentalHealthCommission.gov>. ■

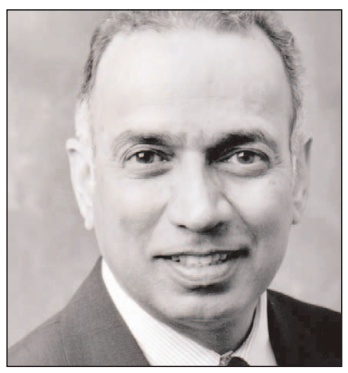
Federal Commission Overlooks Access Concerns, Says Psychiatrist Member

BY KATE MULLIGAN

New Freedom Commission on Mental Health member Anil Godbole, M.D., expanded on the problems uncovered by the commission and talked about the work yet to be done in an interview with *Psychiatric News*.

The commission studied documents such as the 1999 "Surgeon General's Report on Mental Health," which pointed out a host of problems with the country's mental health care system, he noted.

"The situation has deteriorated since that report because there were no significant policy changes in response to the findings," Godbole said.



Anil Godbole, M.D.: "It's up to the consumers and their families to coordinate care. They are least able to do it, however, because of the emotional toll of mental illness."

Godbole is chair of the psychiatry department at Advocate Illinois Masonic Medical Center and president of the National Association of Psychiatric Health Systems. He co-chairs the economic affairs committee of the Illinois Psychiatric Society and is chair-elect of the Behavioral Health Steering Committee of the Illinois Hospital Association.

The commission heard public testimony from consumers and their families, as well as formal presentations from advocacy and medical specialty organizations, including APA, and researchers.

What is labeled the mental health system can't even be called a system, said Godbole. "So many agencies and programs are involved with mental health, child welfare, education, criminal justice, primary care. There's no single accountability."

"It's left to the consumers and their families to coordinate care," he added. "They are least able to do it, however, because of the emotional toll of mental illness."

Godbole pointed to "workforce issues" as a recurring problem mentioned in testimony.

That problem is more complicated than a simple lack of trained mental health personnel. Many of the most successful programs require an interdisciplinary approach. "There is, however, a silo or guild approach to training, so that practitioners whose skills should be coordinated to provide effective mental health care are not prepared to work together," he said.

Primary care settings, jails, nursing homes, and other long-term-care facilities have replaced the failed mental health system as inadequate sources of treatment, he said.

Godbole identified the crisis in access to inpatient care as an important problem that had not yet surfaced as a major issue for the commission.

He said that advocacy groups and medical specialty organizations had testified about a systemic reduction in funding for public and private mental health services.

"The question about the adequacy of resources will come up as we continue our work," he said. Because of systemic fragmentation, funds for mental health are spread across the budgets of various agencies.

The good news, according to Godbole, is that with advances in science and service-delivery methods, effective treatment is available.

The bad news is that effective treatment reaches only a few people.

"We will look more into access to quality care," he said. "How many of the problems relate to funding issues? Workforce training? Fragmentation?"

Godbole said the commission will need to find ways of incentivizing the implementation of best practices by reimbursement strategies. ■

legal news

Advocate

continued from page 17

and "it made sense to me to live up to what I was told I was—conduct disorder."

Another problem that can occur in the mental health system is that adolescent girls with substance abuse disorders substitute the substance they were abusing with the anti-anxiety medications prescribed to them.

Prescott said that steps need to be taken to divert adolescent girls away from the juvenile justice system and into comprehensive treatment programs or peer programs.

At the very least, she said, institutions should adopt policies to avoid retraumatization of adolescent girls with abuse histories. Such policies enforce "the regulation of women during vulnerable procedures such as disrobing, showering, and intrusive medical exams," Prescott said.

"I don't want to wait until girls violently act out before we hear what they are trying to tell us, which is that they are in trouble." ■