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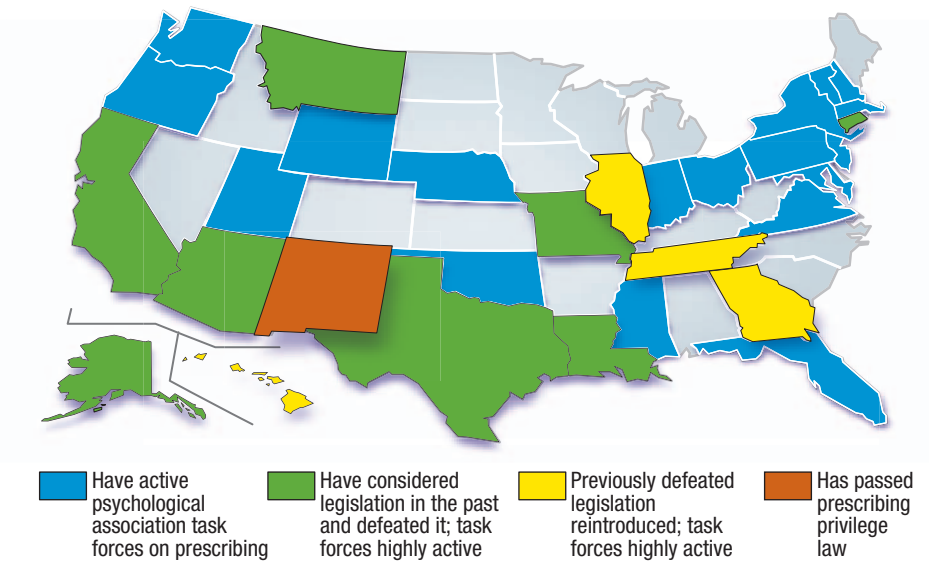
"see" references appaer on pages 5, 8, 11, 19, 23, and 40

New Mexico Governor Signs Nation's Only Psychologist-Prescribing Law

The first of what may well become 50 rounds in the psychologist-prescribing battle is now history. APA is analyzing and preparing strategy for rounds to come. A response from APA leaders appears on page 3.

BY JIM ROSACK



Sources: APA Division of Government Relations and American Psychological Association

With the signature of Gov. Gary Johnson (R) on the evening of March 5, clinical psychologists in the largely rural southwestern state of New Mexico became the first in the nation to be legally eligible to qualify to prescribe psychotropic medications to patients with mental illnesses.

Four other states—Georgia, Tennessee, Illinois, and Hawaii—have reintroduced previously defeated legislation granting prescribing privileges to psychologists. And that is only the beginning. To date, eight other states have introduced, but defeated, similar legislation. According to the American Psychological Association, 31 state psychological associations currently have prescription-privilege task forces actively lobbying their state legislatures (see map).

APA President Richard Harding, M.D., issued a statement March 6 deploring the decision of the New Mexico legislature and the governor to enact the precedent-setting legislation.

"The new law," Harding said, "is the result of a cynical, economically motivated effort by some elements of organized psychology to achieve legislated prescriptive authority without benefit of medical education and training." He emphasized that "psychology prescribing laws are bad medicine for patients."

The governor's signature capped a feverish few weeks of meetings and negotiations between legislators, the governor, and representatives of the Psychiatric Medical Association of New Mexico (PMANM), the New Mexico Medical Society (NMMS), and the state psychological association.

However, in spite of strong efforts by psychiatrists to inform the governor of concerns over patient safety, he seemed to base his decision on a controversial compromise negotiated during the last few days of the legislative session between NMMS and the psychological association. Amendments to the bill by these two groups centered on training requirements not supported by PMANM. Nonetheless, the amendments effectively killed efforts to defeat the legislation.

"What I found," Gov. Johnson told *Psychiatric News*, "and we had several meetings about this over a period of time, but what I found was that no one that I talked with objected to psychologists being given the right to prescribe drugs, as long as they received the proper training. And so from [the psychiatrists], that would only be proper medical school training.

"Our law will require the board of medical examiners and the board of psychology to get together and hammer out exactly what the proper training is. I am confident that they'll come up with a training program that is satisfactory to both sides and that will ensure the safety and welfare of New Mexico's citizens, while at the same time expanding availability

see ***Psychologists*** *on page 13*

Last of Ritalin-Based Lawsuits Against APA Comes to a Close

The misguided legal saga that found APA defending itself in five jurisdictions against allegations that it conspired with a drug company to boost sales of Ritalin has died with barely a whimper.

BY KEN HAUSMAN

And then there were none. The plaintiffs in the fifth of five Ritalin-related lawsuits against APA and Novartis Pharmaceutical have withdrawn their class-action suit.

The last of the suits to come to an early end was the one filed in federal court in New Jersey, and it was withdrawn by the plaintiffs on February 5. Similar suits in California, Florida, Texas, and Puerto Rico have already been dismissed by judges or withdrawn by the plaintiffs before they got to trial (*Psychiatric News*, June 15, 2001; August 17, 2001; September 21, 2001).

All five of the suits alleged that APA and Novartis engaged in an illegal conspiracy to boost the sales of Novartis's Ritalin brand of methylphenidate and thus improve the company's bottom line. The suits charged that to achieve these increased profits for Novartis, APA and the drug company conspired to define the diagnosis of attention deficit disorder (ADD), and later attention-deficit/hyperactivity disorder (ADHD), which have appeared in the last several editions of APA's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, in an unnecessarily broad manner. The suits then allege that APA and Novartis touted the efficacy of Ritalin as a treatment for the disorder.

Ritalin, which came on the market in 1955, was developed by Swiss drug maker Ciba-Geigy. That company merged with

see ***Ritalin Suits*** *on page 37*

New Data Reduce One-Year Mental Disorder Prevalence

By applying a "clinically significant" criterion to previous survey results, psychiatric epidemiologists find that the one-year prevalence rate for any mental or substance use disorder is 19 percent rather than about 28 percent.

BY JOAN AREHART-TREICHEL

What is the one-year prevalence rate for any mental or substance use disorder in the United States? Two large community surveys have provided answers in recent years, and the answers have been 28 percent to 30 percent.

Now a lower figure—19 percent—is reported in the February *Archives of General Psychiatry* by a team of psychiatric epidemiologists. This new figure represents about 19 million Americans fewer than the 28 percent rate. The new figure also more accurately reflects the true picture than the old rates, according to the epidemiologists.

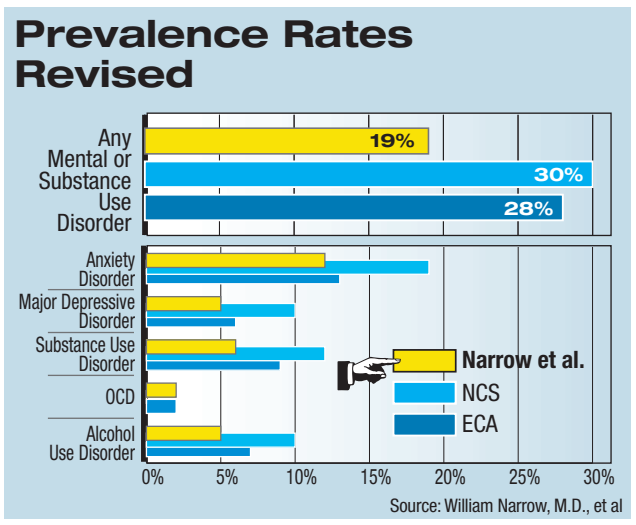
The epidemiologists are William Narrow, M.D., Darrel Regier, M.D., and Donald Rae of the American Psychiatric Institute for Research and Education (APIRE), along with Lee Robins, Ph.D., of Washington University School of Medicine.

The National Comorbidity Survey (NCS) and the National Institute of Mental Health Epidemiologic Catchment Area Program (ECA) are the two large community surveys that yielded the one-year prevalence rates for any mental or substance use disorder of 30 percent and 28 percent, respectively. They are also the surveys that have provided one-year prevalence rates for specific mental or substance use disorders.

However, there are several problems with these surveys: They have produced discordant results, and the prevalence rates that they have yielded are considered by some authorities in the psychiatric epidemiology field to be implausibly high. In fact, as Narrow and his colleagues pointed out in their study report, "If these prevalence rates are taken as a proxy for mental health treatment need, the mental health system would have to expand enormously to meet this need. . . ."

So Narrow and his team decided to reanalyze data from the two surveys, requiring that a "clinical significance" criterion be met before any mental health symptoms could be classified as mental disorders. The rationale? It would be in keeping with the *DSM-IV* specification that mental health problems must be "clinically significant" before they can be truly considered mental disorders.

The researchers analyzed the answers of survey participants to questions such as whether the symptoms they were experiencing were interfering with their lives, whether they had told a professional about their symptoms, and whether they were using medication for their symptoms. If answers to such questions were yes, then the participant's symptoms were considered a mental disorder. If the answers were no, then the symptoms were not considered a mental disorder.



Researchers have found new one-year prevalence rates for mental and substance use disorders by reanalyzing data from the National Comorbidity Survey and the NIMH Epidemiologic Catchment Area study.

For instance, the NCS's one-year prevalence rate for any anxiety disorder had been 19 percent before Narrow and his colleagues applied a clinical-significance criterion to the data. Afterward, the prevalence rate was 12 percent. The ECA's one-year prevalence rate for bipolar I disorder had been 0.9 percent before the clinical-significance criterion was applied; afterward it was 0.5 percent.

The investigators then pooled their revised findings for the two surveys to come up with one-year prevalence rates for specific mental disorders and for all disorders combined. If there was a difference between the two surveys regarding a particular disorder, they conservatively selected

see ***Prevalence Rates*** *on page 40*

Lessons Learned Will Help Capture Future Victories

BY RICHARD K. HARDING, M.D.
STEVEN M. MIRIN, M.D.
JAY B. CUTLER, J.D.

As you can see in the article on page 1, New Mexico Gov. Gary Johnson (R) has signed HB 170, giving prescribing privileges to psychologists in New Mexico who have undergone 450 hours of classroom instruction by undefined expert teachers and an accredited supervised clinical training program, not necessarily including any inpatient experience. This makes New Mexico the first—and one hopes the only—state to permit psychologists to prescribe drugs and concludes a 20-year effort by organized psychology to secure the right to prescribe.

Because of the outcome, and particularly because we must be prepared for a newly energized push for prescribing privileges across the states, we wanted to give you a detailed analysis of the factors that led to the outcome in New Mexico, together with a summary of the major lessons we have learned as we prepare for additional battles. We apologize for the length of this article, but the situation is complex.

Let us note at the outset that the Psychiatric Medical Association of New Mexico (PMANM), APA, New Mexico's family physicians, the AMA, and psychology groups opposed to prescribing did the utmost to prevent this outcome. We wish to express APA's and our personal thanks for the efforts of our membership and dedicated district branch/state association (DB/SA) staff to defeat the bill in New Mexico. We note that we have received reports that organized psychology spent as much as $500,000 on its New Mexico strategy, and we have no idea at this time if this included campaign contributions.

Passage of HB 170 follows the decision of Gov. Johnson, having met with New Mexico psychologists and psychiatrists jointly and individually, to place the bill on his "call list" in a year usually reserved only for legislation related to the budget. The "call list" decision of the governor gave the bill a critical boost in momentum and allowed legislators of the governor's party to sense his support, a development that psychologists and their allies exploited by focusing on his signal of willingness to sign the bill if passed.

Although augmented by the determination of psychiatrists across the country, New Mexico psychiatry's struggle to defeat the prescribing bill was complicated by a variety of factors. For example, although any psychologist-prescribing initiative was strongly opposed by PMANM, the New Mexico Medical Society (NMMS) developed an alternative to HB 170 that was patterned on the training required for physician assistants. Action on that alternative was entirely superseded by a subsequent "compromise" brokered between NMMS and the New Mexico Psychological Association at a meeting convened at the direction of House Judiciary Chair Ken Martinez. Martinez requested that NMMS President Alan Haynes, M.D., a urologist, represent the opponents of the prescribing initiative. While PMANM was informed of the meeting, it was not presented as a negotiating session, and no psychiatrist was invited to participate.

While we will never know the specifics of the meeting, despite the clearly stated opposition of New Mexico psychiatrists and APA to any deal, NMMS made a political decision to compromise based—we can only assume—on competing political interests and the assessment by its own lobbyists that the legislation would pass. The endorsement of the medical society of a "compromise" negotiated without any involvement by psychiatrists was lamentable and provided the fig leaf of medical-board oversight. This, in turn, allowed proponents to claim that NMMS "supported" psychology prescribing, clearly complicating efforts to defeat the bill and secure a gubernatorial veto.

In fact, we have received a post-action analysis from a source close to the governor that strongly suggests he had little enthusiasm for prescribing but was persuaded that the NMMS-proposed medical-board oversight was sufficient to ensure that patient safety would not be compromised, and thus decided to sign the bill rather than risk enactment of subsequent legislation with no medical oversight after his term in office expired. We appreciate the creative logic, but suggest he failed his constituents.

With respect to APA's efforts in New Mexico, we provide the following brief summary:

- APA, chiefly through funding support from the Commission on Public Policy, Litigation, and Advocacy, committed substantial amounts of direct financial support to PMANM, as well as countless staff hours of assistance.

- An action alert to the APA national grassroots network and Assembly targeted members of the New Mexico Senate Public Affairs Committee, as well as Gov. Gary Johnson. An earlier action alert was aimed at members of the New Mexico House Judiciary Committee.

- The American Academy of Child and Adolescent Psychiatry sent an action alert to its New Mexico members.

- Staff of APA's Division of Government Relations (DGR) helped prepare a letter from Dr. Harding to Gov. Johnson and to members of the House committee. DGR staff also solicited or helped produce letters from PMANM members and other psychiatrists.

- Through a conference call, Dr. Harding, APA President-elect Paul Appelbaum, M.D., and Richard Ciccone, M.D., chair of APA's Commission on Public Policy, Litigation, and Advocacy, along with DGR staff, met with seven members of the PMANM leadership. Offers of assistance were reiterated, and the message was reinforced that APA and PMANM continue to oppose any bill that provides for prescribing via any method other than medical training and residency.

see ***Capitol Comments*** *on page 36*

Dr. Harding is president of APA, Dr. Mirin is medical director, and Mr. Cutler is director of the Division of Government Relations.

Mixed Reviews Greet Bush's Insurance-Expansion Proposal

Those in search of mental health benefits face significant obstacles in the open insurance market.

BY KATE MULLIGAN

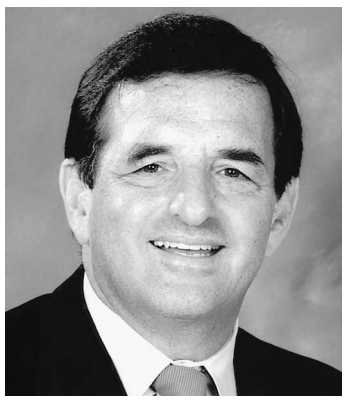
What do the U.S. Chamber of Commerce and AFL-CIO have in common? Usually not much, but at the moment they are united by a common concern about the growing number of uninsured Americans.

Those national organizations, along with 10 others, released data in February showing that 2.2 million Americans lost their health insurance in the past year, on top of the more than 39 million who were uninsured as of 2000.

In his State of the Union address and subsequent speeches, President George W. Bush addressed the problem of the uninsured with an $89 billion proposal to use tax credits to help make private health insurance more affordable to those who have lost their jobs or who are otherwise not eligible for employer-sponsored insurance.

Under Bush's proposal, eligible families with two or more children and incomes under $25,000 could receive up to $3,000 in credits to cover as much as 90 percent of the cost of purchasing health insurance.

The credit phases out at $60,000 for families and $30,000 for individuals. The credits are refundable, so their value does not depend on taxes owed. The credit could be issued in advance, rather than waiting until a family or an individual filed a tax return at the end of the year. Insurers would reduce the premium cost by the size of the family's credit and be reimbursed by the federal government.



Barry F. Chaitin, M.D.: The president's plan "offers significant opportunities to expand coverage [but] the devil is in the details."

States would also have the option of letting certain tax credit recipients purchase coverage in their Medicaid or State Children's Health Insurance Program (SCHIP) managed care plans, but there would be no requirement that states do so.

Barry F. Chaitin, M.D., chair of APA's Council on Healthcare Systems and Financing, commented on the plan, "The president's plan deserves serious consideration because it offers significant opportunities to expand coverage. However, the devil is in the details. We need to look at how issues of insurance availability and cost will affect people who need mental health services."

At a hearing of the House Ways and Means Committee on February 13, Rep. Pete Stark (D-Calif.) called the plan "inadequate." He added, "There's no way we're giving them decent coverage at a price they can afford," according to a February 14 report on the Web site <kaisernetwork.org>.

Ron Pollack, executive director of Families USA, said in a press release, "The individual tax credits proposed. . .are far too small to make health coverage affordable for low-income workers."

In testimony submitted for the record at the February 13 hearing, Jonathan Gruber, a professor of public finance at the Massachusetts Institute of Technology, wrote that while Bush's proposal would likely cover approximately 3.3 million uninsured people, an additional 1.4 million people would lose their insurance because it would lead employers to drop coverage.

"Tax credits could offer benefits to some of the healthier people who are uninsured."

On March 6 House Republican leaders took the tax-credit proposal out of a Republican-sponsored economic stimulus bill, which then passed the House on March 7, but the idea of tax credits to address the problem of the uninsured likely will resurface.

Last April a panel of policy analysts and insurance company representatives convened by the Center for Studying Health System Change identified potential problems with the use of this financing method.

According to the issue brief that resulted from the meeting, "Stand-Alone Health Insurance Tax Credits Aren't Enough," the panelists agreed that "the individual market's major flaw is risk selection, or whether an insurer attracts a disproportionate number of sick or healthy people."

Underwriting policies result in higher premiums for people who are older or sicker, if they are even offered coverage at all. Age alone can be a significant determinant of an individual's premium cost in the individual market

Presenters at a meeting last August convened by the Alliance for Health Reform on "Making Tax Credits Work" offered de-

tails about the likely fate of insurance applicants on the open market.

Karen Pollitz, project director of Georgetown University's Institute for Health Care Policy and Research, created seven hypothetical applicants with common problems such as allergies, a knee injury, depression, and high blood pressure combined with obesity.

Working with the National Association of Health Underwriters, she obtained 60 responses from insurance companies for each applicant (a total of 420). Pollitz found "enormous" variations in the premiums charged to each individual.

Many offers excluded conditions such as depression and allergies for which the individual would need treatment. Most offers were "substandard" in that they were priced at a higher rate than what was advertised or included fewer benefits.

Bob, the hypothetical applicant with a knee injury, received the most favorable offers, but even he was rejected 12 percent of the time and received substandard offers for 63 percent of his applications.

What Will Happen to MH Benefits?

With the help of Nicholas Meyers of APA's Division of Government Relations, Pollitz created Emily, a hypothetical character with situational depression (see box to learn how she fared on the open insurance market).

Deborah Chollet and Lori Achman, health analysts at Mathematica Policy Research Inc., examined the effectiveness of state-run, high-risk insurance pools.

In an August 2001 paper, "Insuring the Uninsurable," they reported that the pools often charge premiums that are high relative to income, include sizeable deductibles and copayments, and restrict annual and lifetime benefits.

Although they are designed for people with serious or chronic illness, the pools "tend to impose preexisting-condition exclusions." Some pools have long waiting lists, and one is closed to new applicants.

The pools typically limit coverage for mental health care, according to the authors. A chart showing mental health benefits for the 29 states with insurance pools shows such limitations as 50 percent copay, low ($25,000) lifetime maximums, and coverage only for inpatient days.

Chollet told *Psychiatric News*, "Tax credits will be of no use for those who want mental health benefits, unless they can find an insurance product to buy that will be affordable and will work for their needs."

Howard Goldman, M.D., a psychiatrist and director of mental health policy studies at the University of Maryland School of Medicine, expressed a similar concern. "Tax credits could offer benefits to some of the healthier people who are uninsured. For many people, however, the help will mean moving from being uninsured for mental health to being underinsured for mental health."

The Web address of kaisernetwork.org is <http://kaisernetwork.org/>. "How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" is posted at <www.kff.org>. The Web address of the Center for Studying Health System Change is <www.hschange.org>. ■

Policies on Open Market Severely Limit Mental Health Benefits

What happens to a woman with situational depression on the open insurance market?

Consider the fate of Emily, a 56-year-old woman whose husband died suddenly in January 2000. She is 5 feet, 4 inches tall, weighs 125 pounds, and does not smoke. Since her husband's death, she has suffered from situational depression, and her internist prescribed 20 mg of fluoxetine a day; otherwise, she is in excellent health.

With the help of Nicholas Meyers of APA's Division of Government Relations, Karen Pollitz, project director of Georgetown University's Institute for Health Care Policy and Research, created the hypothetical character of Emily and then sent her medical record to 60 insurance companies as part of a study of the availability of insurance to individuals.

The 60 insurance companies are in eight communities that are diverse in size and geographic location. They are in states that set few limits on medical underwriting by carriers in the individual market. From six to nine insurers participated in each market.

Insurers were fairly evenly divided on whether to reject Emily, apply a surcharge to the premium, or impose both benefit limits and a premium surcharge. Overall, Emily received 46 offers (77 percent), including nine offers of standard coverage at the standard rate, and 14 denials (23 percent).

Twenty-three offers imposed restrictions on covered benefits including these:

- One excluded treatment for depression.
- Six excluded treatment for all mental/nervous disorders.
- Eight increased cost sharing for psychotropic drugs.
- Seven increased the cost sharing for all prescription drugs and imposed coinsurance (paying a percentage of the fee rather than a copay) on all doctor visits.

Almost two-thirds (30) of Emily's offers imposed premium surcharges, averaging 26 percent. The average premium offered to Emily was $338 a month, or $4,056 a year. Monthly premiums ranged from a high of $916 to a low of $160. In most markets, the cost of coverage offered Emily varied by a factor of 2:1 or more. Her offers ranged in price from $1,920 to $10,992 a year.

Of the 60 policies studied, six policies had no coverage for mental health or substance abuse. Low lifetime and annual caps were used most often to limit coverage for mental health care. Twenty-seven policies imposed lifetime caps, usually of $10,000. By comparison, lifetime caps for other health services ranged from $1 million to $6 million under all of the policies studied. Thirty-three policies imposed annual caps, usually of $3,500 or less.

In large group health plans, the Mental Health Parity Act of 1996 requires parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on other medical/surgical benefits. The act does not require parity for other terms of mental health coverage (such as cost sharing or the number of covered visits), nor does it apply to substance abuse benefits.

LILLY SYMPOS NELSON
P4C

BMS CORPORATE
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NIH Shows Taxpayers What Their Dollars Are Buying

In a detailed report, the NIH outlines its view of what taxpayers are getting for their multibillion-dollar-a-year investment in research.

BY JIM ROSACK

Responding to a request from Congress to "prepare a plan to ensure that taxpayers' interests are protected," the National Institutes of Health (NIH) has issued a sweeping report, reviewing the institutes' vision of taxpayers' return on investment. In addition, the report calls for significant changes in the way the institutes manage grants to allow each institute to better track investments in research and any development of medical technology, drugs, or devices arising out of NIH-funded research.

The report of the congressional conference subcommittee on appropriations for the departments of Labor, Health and Human Services, and Education instructed the NIH to look at taxpayers' investment in the development of new FDA-approved medications. More specifically, Congress asked NIH to prepare a list of drugs that had reached "blockbuster" status—defined as having reached $500 million in annual sales—and had NIH funding at some point in development.

NIH staffers identified 47 medications meeting the blockbuster definition during Fiscal 2001. Of those, three patented products, marketed under four brand names—epoetin alfa (Epogen/Amgen Inc. and Procrit/Ortho Biotech), filgrastim (Neupogen/Amgen Inc.), and paclitaxel (Taxol/Bristol-Myers Squibb)—were developed using NIH-funded technology.

Epoetin alfa, which is used to stimulate the growth of red blood cells, was developed by researchers at Columbia University with support from NIH grants. The university licensed the technology to Amgen and Johnson & Johnson (which markets it under its Ortho Biotech subsidiary).

see ***Taxpayers*** *on page 38*

Drug Industry Notes 2001's New Products

Drug companies are touting the industry's successes as evidenced by 32 new treatments approved by the FDA in 2001.

BY JIM ROSACK

While the National Institutes of Health is having difficulty quantifying U.S. taxpayers' return on their investment in research (see story at left), the drug industry is heralding recent successes in its quest to "bring newer and better medicines to patients." Among 32 new treatments approved by the Food and Drug Administration (FDA) in 2001 were one for schizophrenia and one for Alzheimer's disease.

The Pharmaceutical Research and Manufacturers of America (PhRMA), the industry's largest trade group and primary lobbying organization, said last month that those 32 new treatments—22 medications, two vaccines, and eight "biologics"—are the result of a decade-long record investment by pharmaceutical companies in research and development.

In 2001 the industry spent an estimated $30.3 billion in drug development, a 16.6 percent increase over research and development expenditures during 2000.

Included in the FDA's 2001 approvals were Pfizer's new antipsychotic, ziprasidone HCl (Geodon), and Janssen Pharmaceutica's new treatment for mild-to-moderate Alzheimer's disease, galantamine hydrobromide (Reminyl).

Among the 20 other medications approved during the year were five for heart disease, five for infectious diseases, three for cancer, two each for arthritis, glaucoma, and migraine headaches, and one for HIV/AIDS. Two new vaccines were also approved.

In addition, eight biologically engineered treatments were approved for anemia, leukemia, rheumatoid arthritis, prevention or treatment of hepatitis A, B, and/or C, and sepsis.

The Tufts University Center for the Study of Drug Development estimates that the 32 new products will be used to treat diseases that lead to an estimated $250 billion in annual costs for health care, disability, lost productivity, and mortality.

Development of the new treatments was not only expensive, it also was time consuming. According to estimates by Tufts, each of the 32 new medications represents an average development cost of $802 million, a 250 percent increase over average development costs 10 years ago.

On average, according to the Tufts data, development took 10 to 15 years. The 22 medications and two vaccines approved last year spent an average of 16.4 months under review by the FDA. The eight biologics took slightly longer to win government approval, 19.6 months.

Interestingly, Pfizer's ziprasidone took the longest—46.7 months—due to significant concerns over its adverse-event profile (*Psychiatric News*, March 2, 2001), while the approval of galantamine went through in a very average 17 months. ■

Senate Hears Proposals to Remedy Shortage of Geriatric Specialists

Congress must address the shortage of geriatric physicians by increasing funding of training programs and removing disincentives in Medicare policies to treating geriatric patients, says APA.

BY CHRISTINE LEHMANN

Health care professionals, including physicians, nurses, psychologists, and therapists, are not training enough of their members to treat the elderly, who are rapidly increasing in numbers, warned members of the Senate Special Committee on Aging in February.

One of the professions where there is already a shortage is geriatric psychiatry. APA and the American Association for Geriatric Psychiatry (AAGP) pointed out in written statements to the committee that since 1991, 2,508 psychiatrists have been certified in geriatric psychiatry by the American Board of Psychiatry and Neurology. AAGP predicted that twice as many geriatric psychiatrists will be needed by 2010 to meet the projected demand for service. An additional 1,221 academic geriatric psychiatrists will be needed by 2010 to train future residents in that specialty, added AAGP.

These projections are based on the expected rapid growth of the elderly population due to the 76 million "baby boomers" who will reach age 65 between 2010 and 2030, according to AAGP. By 2030 older adults will account for 20 percent of the total U.S. population, up from 13 percent in 2000, said AAGP.

As the population ages, the number of older Americans experiencing mental health problems is expected to increase. Nearly 20 percent of those who are 55 or older experience mental disorders, said AAGP. The most common conditions are anxiety, severe cognitive impairment, and mood disorders.

Sen. John Breaux (D-La.) also complained that only three of the 125 medical schools in the nation have a geriatric department, and only 14 require medical students to take a course in geriatric medicine.

APA stated that there are 56 accredited postgraduate programs in geriatric psychiatry nationwide. This additional geriatric training gives general psychiatrists "the in-depth experience in the diagnosis and treatment of mental health disorders in older adults," according to AAGP.

APA and AAGP urged the committee to support the Advancement of Geriatric Education Act (S 1362), which would increase the number of trainees in and funding for geriatric residency and fellowship programs. The bill, introduced by Sens. Tim Hutchinson (R-Ark.) and Larry Craig (R-Idaho) last year, would allow teaching hospitals to add a limited number of training positions in geriatric medicine and geriatric psychiatry without reducing the number of training slots in other fields. The number of training positions funded primarily through Medicare was capped by the 1997 Balanced Budget Act at 1996 levels, according to AAGP testimony.

APA President Richard Harding, M.D., told *Psychiatric News*, however, that "education and training are only a partial solution to a much larger problem, namely, the barriers to delivering medically necessary psychiatric services to older Americans."

Harding complained that Medicare policies continue to pose significant barriers to treating the elderly with mental illnesses. Two longstanding discriminatory policies are the 50 percent copayment required for outpatient mental health services and the 190-day lifetime limit on inpatient treatment in psychiatric hospitals, said Harding.

In addition, state Medicaid plans are required to pay Medicare premiums, deductibles, and copayments for low-income patients. However, the Health Care Financing Administration notified state Medicaid directors in 1992 that payment of the Medicare copayment for outpatient psychiatric services was optional, so many stopped paying it, according to APA's statement to the Senate committee.

"This is double discriminatory treatment of low-income patients who qualify for both Medicare and Medicaid," said Harding.

Psychiatrists who are reimbursed by Medicare continue to experience paperwork hassles due to too many regulations and widespread variations in the way Medicare carriers interpret federal Medicare rules, complained APA. A more recent Medicare problem is the 5.4 reduction in Medicare reimbursement rates for 2001.

APA urged the Senate committee to support several bills designed to fix these and other problems with Medicare:

- The Mental Illness Non-Discrimination Act (HR 599/S 841) would repeal Medicare's discriminatory 50 percent copayment for outpatient psychiatric services. Medicare patients would be charged a 20 percent copayment for all medical services, including psychiatric care.
- The Medicare Regulatory and Contracting Reform Act (HR 3391) would give physicians flexibility in setting up Medicare overpayments, limit the use of repayment extrapolation formulas and prepayment reviews, and require carriers to provide clear and timely responses to physicians' questions. The bill passed the House unanimously last year but has yet to be taken up by the Senate.
- The Medicare Mental Health Modernization Act (HR 1522/S 690) would repeal the 190-day lifetime limit on inpatient treatment in psychiatric hospitals and establish intermediate-level services not currently covered by Medicare.
- The Medicare Physician Payment Fairness Act (HR 3351/S 1707) would address the negative payment update in the 2002 fee schedule and direct the Medicare Payment Advisory Commission to conduct a study on replacing the sustainable growth rate as a factor in determining future payment updates.

APA urged the Senate committee to "take a holistic approach to the problem, addressing the supply of physicians who are trained in geriatric medicine while simultaneously acting to end the tremendous disincentives to patients seeking care for mental illnesses."

The bills can be accessed on the Web at <http://thomas.loc.gov> by searching on the bill number. ■

Intricate Coding Rules Even Baffle Experts

Not even the people trained to use CPT codes can do it accurately, so it's no surprise that the average physician often makes coding errors.

BY MARK MORAN

If coding for evaluation and management seems like working a jigsaw puzzle, take heart: Even the professionals trained to use the Current Procedural Terminology (CPT) codes don't always agree on how to do it.

A survey of certified professional coding specialists who were asked to assign evaluation and management (E&M) codes to hypothetical cases found that they agreed on the appropriate code only slightly more than half the time.

The survey results, published in the February edition of the *Archives of Internal Medicine*, lend some scientific credence to what clinicians everywhere have discovered in their practice.

"The average physician has minimal to no training in CPT coding," said Mitchell King, M.D., an assistant professor of family medicine at Northwestern University Medical School in Chicago and lead author of the report. "Anyone who has been out in practice for a number of years is learning to do it on the fly. It's a very complicated system that coding specialists themselves cannot come to agreement on. I think it raises the question of whether anyone should be audited."

In the study, 300 certified professional coding specialists randomly selected from the active membership of the American Health Information Management Association were sent six hypothetical progress notes of office visits, and 136 surveys were returned.

Coders agreed on the appropriate code to use 58.7 percent of the time. Across individual cases, the level of agreement ranged from 50 percent to 70 percent. Undercoding, relative to the most common or consensus code among the respondents, occurred more commonly than overcoding and occurred significantly more often for established patients. In contrast, for new patients' progress notes, overcoding relative to the consensus code was more common than undercoding.

King and colleagues suggested in their paper that coding criteria are stricter for new patients, requiring more documentation to establish the same service level. In addition, physicians and coding specialists may recognize that caring for new patients requires more effort and that there is more uncertainty in providing this care than for established patients.

For this reason, physicians and coders may feel that new patients are more difficult—and established patients less difficult—and coding levels may reflect this.

A demographic questionnaire, which accompanied the survey, found that coders averaged 10.9 years of coding experience, with an average of 8.3 years' experience coding in physicians' offices.

"It highlights the need for some serious thought about revising a system that is so complex that even people who are trained in school can't apply it consistently," King said.

Chester Schmidt, M.D., chair of APA's Committee on RBRVS, Codes, and Reimbursements, agreed. He said the study is relevant to psychiatrists, who use the E&M codes for inpatient and partial hospitalization, consultation, nursing home visits, and some office visits.

"Psychiatrists, like all physicians, have some difficulty using these codes and selecting the level of service, and they are uncertain about the elements of documentation needed to support it," he said.

Schmidt cited some weaknesses in the study, including the fact that the hypothetical cases themselves were not presented. And he said mail surveys are subject to selection bias, noting that the 136 coders who responded represented fewer than half of the total (300) who were actually surveyed.

Finally, Schmidt noted that some of the variation among the coders may have been due to the survey method itself. "When you mail something like this out, you don't have everyone in one place, so that everyone hears the same thing," he said.

But he said there is no doubt that the rules for E&M coding and documentation are all but byzantine. Especially controversial, he said, are the guidelines for determining the level of "medical decision making"—one of the three E&M components, along with history taking and examination.

The guidelines for that component use a four-by-four grid designed to produce a numerical approximation of medical decision making—a system so complex "it bears no resemblance to the actual practice of medicine," Schmidt said.

Despite vocal protests from physicians, and promises from the AMA and the Centers for Medicare and Medicaid Services (CMS) to revise the medical decision-making guidelines, there has been no action, Schmidt said.

He said that the AMA, which has a copyright on the CPT codes, may have little room for maneuvering to make the codes less stringent. It was the AMA that collaborated with CMS's predecessor, the Health Care Financing Administration, on the Resource-Based Relative Value Scale, and the coding system to go with it, in 1992—partly in response to criticism that the older coding system was insufficiently rigorous, Schmidt said.

"No system has been designed that has been scientifically tested for its validity and reliability," Schmidt noted. ■

Bush's Proposed Health Budget Inadequate, Committee Says

At a budget hearing for the Department of Health and Human Services, Republicans and Democrats unite to oppose the Bush administration's insistence on budget neutrality concerning health care proposals.

BY KATE MULLIGAN

"But" was the word that resounded most frequently at the March 13 meeting of the House Energy and Commerce Committee Subcommittee on Health and Environment about the Bush administration's health care proposals.

Rep. Sherrod Brown (D-Ohio) said to Health and Human Services (HHS) Secretary Tommy G. Thompson, "[Y]ou rightly invest generously in the National Institutes of Health [NIH], which supports research into new medical treatments, but you cut funding for the Agency for Health Research and Quality [AHRQ], which plays a critical role in communicating that research to the medical community and the public."

Many committee members commended the proposed doubling of the NIH budget over five years and the increase of 6.3 percent in the HHS budget for Fiscal 2003 over the previous year. The largest percentage increase will be in funding for bioterrorism efforts. The figure for Fiscal 2003 in the HHS budget is $4.3 billion, a 45 percent increase over Fiscal 2002.

The members followed their praise, however, with concerns about inadequate funding for prescription drugs for the elderly, the use of tax credits to help the uninsured (see page 4), and cuts to programs such as health professions grants (72 percent decrease) and rural health programs (42 percent decrease).

Even Republicans joined in on the attack. Rep. Greg Ganske (R-Iowa) said that Iowa hospitals were "hemorrhaging red ink" because of inadequate Medicare and Medicaid reimbursement for rural hospitals. He asked, "What good will it do for seniors in rural areas to have prescription drugs if there are no hospitals to serve them?"

Rep. Charles Norwood (R-Ga.) argued against the administration's position that any increases in the health budget must be "budget neutral," that is, offset by equivalent cuts in other areas of that budget. He expressed concern about the exodus of physicians from the Medicare system because of recent reimbursement cuts and suggested that the administration's entire budget be searched for potential savings.

Prescription Drugs for Medicare

The administration's proposals for prescription-drug coverage came under the heaviest attack. President Bush proposed spending $77 billion over 10 years to provide prescription drugs to low-income Medicare beneficiaries and $116 billion for unspecified Medicare modernization efforts, including additional prescription-drug coverage. A discount-card program for prescription drugs would offer Medicare-endorsed discount cards to assist beneficiaries with prescription-drug costs.

Model Medicaid drug waivers would allow states to offer drug coverage through Medicaid to individuals with incomes up to 200 percent of the federal poverty level. States receiving drug waivers would be required to do so at no additional cost to the federal government. States could also use waivers to provide drug benefits through Medicare-endorsed prescription-drug cards or use cost-control methods such as prior authorization.

> **"What good will it do for seniors in rural areas to have prescription drugs if there are no hospitals to serve them?"**

Rep. Lois Capps (D-Calif.) called the amount of federal money proposed for drug coverage "woefully inadequate." Brown charged that the drug proposal represented an effort to "go after" entitlements.

He said, "You are using this budget to means-test Medicare and provide drug coverage outside the Medicare benefits package, knowing full well that Medicare's future depends on its ability to deliver comprehensive health coverage and its availability to all seniors, regardless of income."

The most recent projections from the Congressional Budget Office show that national spending on prescription drugs for Medicare beneficiaries over the next 10 years will reach $1.8 trillion, about 10 times more than what Bush proposed for Medicare reform and a drug benefit.

Medicare Managed Care

Bush proposed $4.1 billion over three years to increase the rates paid to insurance companies that participate in Medicare+Choice, the Medicare managed care program. Companies have been pulling out of the program, leading to decreasing benefits and increasing copayments (*Psychiatric News*, December 21, 2001; January 4).

In response to a request for an assurance that an influx of funds to the program would prevent further erosion in the benefits offered by the companies and in their participation, Thompson replied that although

see ***Proposed Budget*** *on page 38*

AACAP Issues Guidelines On Seclusion, Restraint Use

The American Academy of Child and Adolescent Psychiatry has released two new practice parameters on seclusion and restraint and the use of stimulant medications. This first of a two-part series provides information on the seclusion and restraint parameter.

BY CHRISTINE LEHMANN

"If you feel angry, sit on your hands and think about pizza." This is not something you would necessarily expect a child psychiatrist to say to a patient, but Kim Masters, M.D., has found that it works in children with aggressive behavior.

Masters, medical director of a private psychiatric hospital 75 miles south of Savannah, Ga., on St. Simons Island, explained to *Psychiatric News*, "When children are sitting on their hands, they can't throw things or get into a fight. If they are thinking about pizza, they are distracted from whatever is making them angry."

Masters and child psychiatrist Christopher Bellonci, M.D., describe several practical techniques like this from anger management and crisis de-escalation programs in the United States in a new practice "parameter" from the American Academy of Child and Adolescent Psychiatry (AACAP).

The practice parameter emphasizes that teaching children these techniques can prevent the aggressive behaviors that can lead to the need to use seclusion and restraint in psychiatric institutions, including hospitals and residential treatment centers.

The practice parameter discusses behavioral strategies that are nonrestrictive, restrictive, and highly restrictive. The last category includes seclusion and different types of restraint. Also covered is how to use incidents in which seclusion or restraint was used to promote alternative strategies.

Preventing aggressive behavior in children begins with diagnosing and treating the underlying psychiatric illness, according to the practice parameter. "The evaluation of a patient should include a review of aggressive behavior including triggers, warning signs, repetitive behaviors, response to treatment, and prior seclusion and restraint events associated with aggressive acts. [MS]"

MS stands for "minimal standard," which means there is substantial empirical evidence for the recommendation, and it should be applied in all cases unless there is a compelling reason not to follow the standard. All recommendations and techniques in the practice parameter are rated. Other ratings are "CG," which stands for "clinical guidelines" and recommendations based on empirical evidence; "OP," which stands for "options" and refers to practices that are acceptable but not required; and "NE," which stands for "not endorsed."

Treatment planning should include strategies to prevent aggressive behavior, de-escalate negative behavior before it becomes necessary to use restrictive interventions, and psychological and pharmacological treatments for the underlying illness.

"We teach children how to recognize the triggers of aggressive behaviors with the acronym HALTS, which stands for Hungry, Angry, Lonely, Tired, and (keeping) Secrets," said Masters in an interview.

Masters explained that "keepers of secrets become somewhat paranoid in dealing with others and so are irritable and more prone to get angry."

"We encourage children, when one or more of these factors is present, to let the staff know that so they can help monitor [the children's] behavior and prevent them from blowing up," said Masters.

Training staff how to manage children's aggressive behaviors is another important component of prevention, said Masters. "Staff work with children on these techniques through role playing and repeated practice. If children need a timeout in a seclusion room, we use that as an opportunity to review the anger management techniques to prevent further escalations."

The practice parameter encourages hospital staff and the admitting physician to communicate the concepts of self-responsibility and self-control to patients before they are admitted and to enlist the parents' support.

The emphasis should always be on prevention from the first contact with the patient to discharge, said Masters. This approach has resulted in eliminating the use of restraint in the last year and a half that he has been medical director of the Georgia psychiatric hospital.

"We use seclusion about once every other month, compared with seven or eight times a month when I arrived," said Masters. The psychiatric hospital he directs treats an average of 10 children and adolescents at a time.

However, many psychiatric inpatient facilities including residential treatment centers for children "do not hire enough qualified staff to run a program and engage in prevention work with aggressive children at the same time. So crises escalate into seclusions or restraints to keep order," said Masters.

He recommends having a nursing staff-to-patient ratio of 1-to-6. "Each unit should have a registered nurse [R.N.] as the head

*see **AACAP Parameter** on page 38*

Psychologists

continued from page 1

and access of these medications to the patients who need them."

Several factors appear to have been of primary influence in the passage and signing of the law. High on the list of both the New Mexico legislature and the governor, according to numerous sources, was concern over what they see as a critical need for expanding rural access to mental health care.

"There is an absolute need for increased psychiatric care in this state," said Diane Kinderwater, the governor's director of communications. "And that was obviously a factor in [the governor's] decision."

According to the New Mexico Board of Medical Examiners and the AMA's Physician Masterfile, there are between 225 and 250 psychiatrists practicing within the state of 1.8 million residents. Only about 60 of those, or 24 percent, however, practice in the vast expanses of largely rural areas outside Albuquerque and Santa Fe. Census data indicated in 2000 that 61 percent of the total population in the state lives outside those metropolitan areas.

"We all know that there is a crisis in access to mental health care in rural areas," Gail Thaler, M.D., president of PMANM, told *Psychiatric News*. "But the real data are very difficult to actually get."

Gauging Rural Access

The New Mexico Department of Mental Health estimated in its report, "State of Health in New Mexico: 2000," that just under 80,000 adults in the state suffer from a "serious mental illness." In addition, some 45,000 residents under the age of 18 have a "serious emotional disturbance. . .that seriously interferes with the child's role or functioning in family, school, or community activities." If the raw estimates are close to reality, there would be, on average, 500 seriously ill patients for each psychiatrist in the state.

The state report noted "many serious barriers" to access to mental health care in the state, most notably poverty, lack of health insurance, and lack of availability of care in rural settings.

The report strongly suggested collaboration between the Department of Health, the University of New Mexico, and New Mexico State University to develop ways to improve rural access to care. Thaler told *Psychiatric News* that those efforts are now under way. "But in terms of regular acute [nonemergency] access, that's not really adequately covered in many communities."

Albert Vogel, M.D., associate dean for clinical affairs at the University of New Mexico, is APA's Area 7 Trustee. Vogel told *Psychiatric News* that rural access is a concern throughout Area 7 and that the issue was heavily pushed by lobbyists for New Mexico's state psychological association.

The New Mexico Psychological Association's lobbyists tried to use the argument that expanding psychologists' scope of practice to include prescribing would result in an increase in available care.

"Clearly, that is a specious argument," Vogel said. PMANM conducted an informal survey throughout the state and found only one or two counties that were served by a psychologist that were not served by a psychiatrist. Both Vogel and Thaler cited studies in California that have shown that psychologists are no more likely to locate in rural areas than are psychiatrists.

However, one argument used by the psychological association, and reportedly confirmed by many rural nonpsychiatric physicians, resonated loudly with the governor, according to Kinderwater.

"They said that 'You know, psychologists are already out there recommending to primary care physicians what medications to prescribe for which patients,' " said Neil Arnet, M.D., immediate past president of PMANM. And the lobbyists argued that it would be more efficient from both a time and cost standpoint to simply have one person provide counseling and medication.

Arnet was actively involved, along with PMANM legislative representative George Greer, M.D., in the district branch's efforts to defeat the assertions and attended meetings where lobbyists used that argument.

"The governor saw the bill as simply removing a layer of bureaucracy from the process of getting the medications to the patients," Arnet told *Psychiatric News*. "It was a very effective argument."

Allan Haynes Jr., M.D., president of NMMS agreed. "The reality in our state," he told *Psychiatric News*, "is that we are extremely short [of qualified mental health clinicians]. Now, I am a urologist, but I've had some of the clinical psychologists call me, on occasions when I've been the only physician readily available, and say, 'Well, I've got so and so here, and he's going through this type of problem. Many years ago he was a patient of yours, and so would you mind prescribing drug X?'

"Is that good medicine?," Haynes asked, "No. But what do you do? People would rather take some medicine than get nothing at all. That is what we've been doing."

So, Haynes stressed, many rural physicians who already have an ongoing relationship with a clinical psychologist do not see granting them prescribing privileges as any threat professionally or from a patient-safety standpoint.

Brokering Amendments

Haynes said that this general lack of apprehension led the executive council of the state medical society to reassess the chances of the bill's being defeated.

The version of the bill that had passed the state House a year ago and was defeated only by time running out in the Senate was reintroduced in January. That version, HB 170, had less stringent educational requirements, lacked any physician oversight of psychologists' prescribing, and had no provision for the two-year "conditional" period contained in the final version of the new law.

"We were faced with something," Haynes told *Psychiatric News*, "that would send these people out after 18 weeks of Saturday afternoon classes and be able to prescribe."

In addition, Haynes said, early in the session, "I had senators and representatives saying to me, 'I haven't had any phone calls about it. So if it is such a really bad idea, why haven't I been hearing from people?' That pretty much made it impossible to argue with."

Haynes said NMMS had to try to do something to "improve the odds for patient safety."

Little Time Left

Because the legislative session was mandated to last only 30 days, and the governor had decided only at the last minute to add the bill to his legislative agenda for the session. PMANM and NMMS had very little time to rally their opposition to the bill.

PMANM, with assistance from APA's Division of Government Relations, offered several amendments, including a requirement that all psychologist prescribing be under the direct supervision of a physician, similar to the relationship of physician assistants in many states. PMANM also tried to put forward an amendment that would have restricted a psychologist's prescribing to the rural areas that the psychologists were arguing so badly needed the increase in providers. These proposed amendments were made to the House Judiciary Committee but hit a dead end because of subsequent developments.

PMANM, Arnet told *Psychiatric News*, backed the introduction of an alternative bill, HB 305, which was modeled after the state law governing prescribing by clinical pharmacists. This law allows limited prescribing under strict supervision after educational requirements are met.

Just when Arnet thought HB 305 was going to be introduced, Haynes told Arnet that he was meeting with the other side to work on a compromise version of the reintroduced HB 170. "I told him that we would not support any compromise," Arnet told *Psychiatric News*.

At this point, Haynes said he believed that the legislature was prepared to pass HB 170 and send it unamended to the governor for his consideration. NMMS was not confident there was much chance for securing a veto.

On Friday, January 25, the state conference committee considering HB 170 tabled the issue until the following week, expressly to allow the alternative bill to be introduced the following Monday. That Saturday, House Judiciary Chair Ken Martinez called a meeting with Haynes and a representative of the psychological association, and, indeed, they brokered a compromise.

All the psychologists wanted was independent prescribing, Haynes and Arnet told *Psychiatric News*. They did not appear to be as concerned about how it was achieved. Haynes offered to accept independent privileges only if the psychologists accepted strengthened educational requirements, a two-year conditional period of strict oversight, and overall oversight by the state board of medical examiners and the board of psychology. The final language of the law sets minimum educational requirements; however, it calls on both the boards of medical examiners and psychology to work out the final acceptable requirements (see box).

The psychologists agreed, Arnet speculated, because they must have had some indication that the original HB 170, with its less-stringent educational requirements and oversight, was not as much a "done deal" as was being said by both legislators and the governor's office.

"Once [Haynes] negotiated," Arnet said, "the political leverage was lost, and that effectively defeated psychiatry's efforts to kill the bill."

PMANM President Gail Thaler agreed. "When the board of medical examiners was added to the bill, it was sort of the death knell for us in terms of getting the whole thing stopped," she told *Psychiatric News*. "It looked like an endorsement. And I must say, it certainly is better with the amendments than without them."

Arnet believes NMMS's Haynes did what he thought was best under difficult political pressure. "He absolutely wanted to have board [of medical examiner] oversight in the law," Arnet said, "and he got what he wanted when he gave [psychologists] independence after two years."

Both Thaler and Arnet are concerned, however, about vague language in the law regarding the "dual oversight" provisions. For example, the law does not say what will happen if the two boards are not able to agree on the educational requirements they have been entrusted to develop. No provisions exist for resolving any disagreement, which most believe is inevitable.

The Battle Ahead

In an e-mail to members on APA's e-mail distribution lists, APA President Richard Harding, M.D., Medical Director Steven Mirin, M.D., and Director of Government Relations Jay Cutler, J.D., detailed their summary of "the major lessons learned from this battle" and outlined what APA needs to do to "be prepared for a newly energized push" for prescribing laws in other states (see page 3).

Those involved in the New Mexico battle say they have learned valuable lessons that could help in the battles sure to be fought in other states. "We must be more proactive," Arnet said. "Whatever it takes to get in and do personal meetings with the legislators, you have to do it." Letters and phone calls are helpful, he added, but not as effective as a one-on-one meeting.

Both Vogel and Thaler agreed. "You've got to find out what is happening in your state legislature and start very, very early with vigorous lobbying," Thaler said.

Arnet told *Psychiatric News* that combating misinformation is also a key. "The psychologists hired a telephone-survey company to find out how many psychiatrists were in the state. And if you didn't get called, I guess they didn't count you."

A press release issued by the American Psychological Association, announcing the bill's signing, claimed that "there are only 18 psychiatrists serving the 72 percent of New Mexicans who live outside Albuquerque and Santa Fe." The group also claimed there were only around 90 psychiatrists in the state. The numbers are clearly inaccurate based on data from the U.S. Census Bureau, the New Mexico Board of Medical Examiners, and the AMA Physician Masterfile. "Distortions must be dealt with immediately and vigorously," Arnet said. "The longer they hang around, the more 'true' they appear to be."

PMANM members are still feeling stung by the defeat, Thaler and Arnet said. But both agreed that they will do everything possible to ensure the safety of the state's patients. On the battle, Arnet said, "I hope that this will act as a wake-up call."

The text of the New Mexico law can be accessed on the Web <www.legis.state.nm.us> by entering "170" in the "Bill Finder" box on the left. The report "State of Health in New Mexico: 2000" is posted at <www.health.state.nm.us/StateofNM2000>. ■

What Does the N.M. Law Require?

HB 170a, the final version of the bill, amends the state's Professional Psychologist Act to allow a licensed doctoral psychologist to prescribe psychotropic medications. The law, which goes into effect on July 1, sets minimum educational requirements; however, it calls on both the boards of medical examiners and psychology to work out the final acceptable requirements.

The law states that to be granted a conditional prescribing certificate, a psychologist must meet these conditions at a minimum:

- Pass a national certification exam.
- Successfully complete pharmacological training approved by both oversight boards, but composed of at least 450 classroom hours in neuroscience, pharmacology, psychopharmacology, physiology, pathophysiology, physical and laboratory assessment, and clinical pharmacotherapeutics.
- Successfully complete an 80-hour practicum in clinical assessment under physician supervision.
- Successfully complete at least 400 hours treating at least 100 patients under physician supervision.
- Obtain malpractice insurance.

After completing all of the above, a psychologist may prescribe for a period of two years under the supervision of a physician. After two years, the prescribing psychologist may apply for an independent prescribing certificate.

LILLY SYMPOS DUNNER
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Does Mind Meet Brain in Residency? (And What About the Body?)

BY AVRAM H. MACK, M.D.

The 2001 annual meeting theme was "Mind Meets Brain," and one "Residents Summit" was convened there to address this dichotomy in terms of training. In this setting, four eminent psychiatrists debated the situation.

The speakers included Drs. Stuart Yudofsky, co-editor of APPI's *Textbook of Neuropsychiatry* and chair of psychiatry at Baylor; William E. Greenberg, a psychoanalyst and director of the Harvard Longwood residency program; Frances Levin, director of addiction psychiatry training at the New York State Psychiatric Institute; and James Strain, an analyst and director of C/L psychiatry at Mt. Sinai Hospital in New York City, and I moderated. This issue's column summarizes this conversation.

Dr. Yudofsky's view set the pace: It is artificial to separate neurology and psychiatry, he said; instead, we should have one specialty. The mind/brain dichotomy is new to medicine. In 19th-century Germany, he argued, it was right. Then a leader of the field, such as Greisinger, was a professor both of psychiatry and neurology, and there was no difference in the training. Physicians who cared for persons with dementia, general paresis, and melancholy were trained in both fields. Greisinger and his followers, including Alzheimer, Nissl, Kraepelin, and Freud, drove the "neuropsychiatry" of the time: an integrated conceptualization of mind and brain. With this in mind, Dr. Yudofsky proposed that our education should not further a separation between "neurologic" and "psychiatric." Thus, he argued, the training of psychiatrists should include neuroanatomy and neurobiology and that of neurologists should include dynamics and interpersonal relations so as to reduce the artificially maintained divide.

The second speaker was Dr. Greenberg, who, unlike Dr. Yudofsky, argued that the current mind/brain balance is right, but that "we are not yet effectively teaching it." After all, he noted, because of the work of some of today's best-known biological psychiatrists (for example, Kandel and Nemeroff), we are forging new understandings between psychology and biology. And psychoanalysts, such as Fishman at the Boston Psychoanalytic Institute, are analyzing the neurobiology of psychoanalytic concepts. These are the types of findings we should be applying to training.

For Dr. Greenberg, however, the problem is that the brain and mind rarely coexist in the training supervisor. To this point he lamented the conclusion of anthropologist T.M. Luhrman's book, *Of Two Minds*, that trainees are urged to join a psychodynamic or a biological "camp." For Dr. Greenberg, residents know that they must understand the brain, but they also know that, to care for patients, they need to consider the range of etiological factors and a range of therapies. The provisional answer? The best residents "shop around" among supervisors to get and consider every perspective and apply those that help the patient.

Thus, for the most part, the current mind/brain model has worked, but perhaps the biopsychosocial approach does not get taught. For Dr. Greenberg, all programs owe their residents the opportunity to make an independent biopsychosocial formulation on every patient. It is apparent that some programs are not preparing residents to bring the mind and the brain together.

Addiction psychiatry is a field that could logically integrate the mind/brain issue. Unfortunately, according to Dr. Levin, this has not been the case. Developments in the biological measurement and analysis of brains of persons who are addicted to substances or who are intoxicated or dependent upon substances are countered by a tradition of clinical work that is psychological and spiritual. She noted that there is even some resistance to the use of medications in substance abuse treatment programs, perhaps because those programs are led by nonphysicians. This has implications for the mind/brain dichotomy because trainees in our fellowship programs are not learning the modalities that are used in the "real world." A real challenge for educators in the substance abuse arena is how to develop a curriculum that integrates the most current research with established modalities, especially when the practitioners do not read the same journals that psychiatrists do.

For Dr. Strain, the body, "subsumed as Axis III," was an area inappropriately omitted from psychiatry's mind/brain dichotomy. The body deserves consideration in any psychiatric education that is comprehensive and integrated. Thus, he argued, the field should recognize both biologic and psychologic aspects of psychopathology, but not necessarily compacted under one intellectual frame. Why, he asked, should trainees in psychiatry not be expected to master many different topics? Should not physicians with their 11 billion neurons be able to do the same for intrapsychic conflict, biologic concepts, psychologic concepts, and end organ dysfunction?

Thus Dr. Strain agreed with Dr. Yudofsky that there is a need for integration, but he proposed many approaches. Otherwise, he averred, we are babying trainees. A good psychoanalyst, in this manner, recognizes

see ***Residents' Forum*** *on page 40*

Dr. Mack is APA's member-in-training trustee. He can be reached by e-mail at avram_mack@hotmail.com.

Sports and Mental Health In Annual Meeting Spotlight

As Americans begin to participate in sports at ever-earlier ages and continue to participate later in life, psychiatrists will benefit from knowing more about the impact of sports on the lives of their patients, children, and spouses.

Three leading sports psychiatrists will join with three outstanding athletes to present the symposium "Sports Through the Life Cycle" on Wednesday, May 22, at 2 p.m. at APA's 2002 annual meeting in Philadelphia.

The sports psychiatrists are Ronald Kamm, M.D., a clinical faculty member at MCP-Hahnemann who has worked with elite athletes at all levels; Toni Baum, M.D., a George Washington University sports psychiatrist who has also worked with Brown University athletes; and Joshua Calhoun, M.D., of St. Louis University and a former psychiatric consultant to the St. Louis Rams.

The athletes are Marvis Frazier, a former heavyweight boxing contender and son of Joe Frazier; Wendy Williams, a U.S. bronze medalist in diving at the 1988 Olympics in Seoul; and Gary Cobb, a former NFL linebacker and current Philadelphia-area sportscaster.

Kamm will lead the discussion on "The Pros and Cons of Coaching One's Own Child." As part of his presentation, he will review the relevant literature, discuss questions addressed to a sports psychiatry Web site, and share his experiences as a coach and parent. Frazier will then speak on what it was like having his famous father coach and manage him throughout his career. A father himself, Marvis will also discuss his experiences as a parent coaching his daughter in basketball.

Baum will lead the segment on "The Mid-Career Athlete—Coping With Psychiatric Illness." She will address the pressures on athletes during their peak years and the treatment approaches most successful when an Axis I disorder intervenes. She will also discuss the spinal injury that prevented her from competing in the 1992 Olympics, an event that precipitated a depression for which she belatedly, but successfully, sought treatment.

The symposium will wrap up with "When the Cheering Stops: Career-Termination Issues in Athletes," led by Calhoun. He will speak of career-termination issues in athletes and the counseling approaches most effective in helping the athlete transition to a new phase of life. Cobb, a former linebacker for the Dallas Cowboys and Philadelphia Eagles, will then talk about the ways in which he and his teammates dealt with the stresses of retirement.

Each segment will include a videotape introducing the athlete-discussant and showing highlights of his or her career. Those who attend the symposium will have ample opportunity to offer comments and ask questions of the presenters and the athletes. ■

"Remember the Titans"

The coaches made nationally famous by the 2000 movie "Remember the Titans" are participating in a session on the movie at APA's 2002 annual meeting in Philadelphia. The coaches, now retired, are Herman Boone and Bill Yoast. The session will be held on Tuesday, May 21, at 2 p.m. in media session 17.

Next to a family, a team is one of the most influential groups to which an individual ever belongs, according to session chair Ronald Kamm, M.D., a sports psychiatrist. The intensity of that relationship can be seen in "Remember the Titans." The movie is based on the inspiring story of the 1971 integration of three high schools—two black and one white—into one high school in Alexandria, Va., and its football team. Not only are black students bused to the school over the objection of the white community, but a black coach—played by Academy Award-winner Denzel Washington—is brought in to a replace a beloved, highly successful white coach, who is demoted to assistant coach. Nonetheless, the coaches are determined to overcome the racism that threatens to destroy the team, and they go on to produce a squad whose members respect one another and become champions.

How to Register

There are two easy ways to register for APA's 2002 annual meeting in Philadelphia, May 18 to 23:

- Go to APA's Web site at www.psych.org, click on the annual meeting logo, and select "Online Registration." Also, reserve your hotel room by clicking on the link beside "Members" under the annual meeting logo.
- Fill out the forms in the Advance Registration Information Packet, which was mailed to all members in January. If you have not received your packet, call the APA Answer Center at (888) 35-PSYCH; from outside the U.S. and Canada, call (202) 682-6000.

The deadline for advance registration is **April 13** for U.S. and Canadian registrants and **April 6** for all others.

Franklin's Lasting Legacy On View in Philadelphia

Benjamin Franklin's inventions and statesmanship are legendary. But a visit to Franklin Court in Philadelphia reveals that he was also a printer, writer, and postmaster. Science lovers won't want to miss the Franklin Institute Science Museum.

BY CHRISTINE LEHMANN

Benjamin Franklin made his home in Philadelphia during much of his adult life. Franklin came to the city from Boston in 1723 at age 16 and began working as a printer. He later bought the *Pennsylvania Gazette* and wrote and published the popular *Poor Richard's Almanack* in 1732.

His interest in literature and philosophy led him to establish a circulating library and to organize a debating club that became the American Philosophical Society, which exists today. Franklin also helped establish an academy that eventually became the University of Pennsylvania.

As a scientist he invented such diverse items as the Franklin stove, bifocal eyeglasses, and a glass harmonica. He is more widely known for inventing the lightning rod.

Franklin also held numerous public offices including deputy postmaster general of the colonies from 1753 and 1774. His long career as a diplomat and statesman began as a state delegate to the Albany Congress in 1754. He was the state's representative to the British Crown on various matters, and he considered making England his permanent home. But his love for his homeland and devotion to individual freedom drew him back to America in 1775.

Franklin went on to become one of America's greatest statesmen and diplomats. A major final achievement was helping to design the first congress that crafted the Constitution of the United States.

What to Visit

For a good overview of Franklin's accomplishments, visitors should explore Franklin Court, which is on the historical walking tour described in the February 15 issue of *Psychiatric News*. This is where Franklin and his wife, Deborah, lived. The outline of the house is represented by steel girders, and excavated sections are visible. Also on the site is a museum highlighting different stages of Franklin's career and interactive exhibits that children will enjoy.

Also of interest to history buffs are the 1786 houses on Market Street that Franklin rented out, including the Printing Office and Bindery. The house at 322 Market Street is the restored office of the *Aurora and General Advertiser*, published by Franklin's grandson. Visitors can cap off a visit by going next door and having a letter postmarked at the Benjamin Franklin Post Office.

The Library Hall, also on the historical walking tour, is the 1954 reconstruction of Franklin's old Library Company, the first lending library of its type in the colonies. It contains a fascinating collection of documents including Franklin's will and Jefferson's handwritten copy of the Declaration of Independence.

Across the street is the Philosophical Hall, home of the American Philosophical Society, founded by Franklin. The society continues to have an international reputation for promoting knowledge in the sciences and humanities. The interior is not open to the public.

Christ Church Burial Ground, located at Fifth and Arch streets, is where Franklin and his wife are buried, along with another of their famous contemporaries, Benjamin Rush.

Franklin Institute Science Museum

Science lovers will enjoy visiting the Franklin Institute Science Museum at Logan Circle (20th Street and Benjamin Franklin Parkway). The complex is divided into four sections. The first is the Franklin National Memorial, with a collection of authentic artifacts and possessions. The second section features science and technology from the 1940s to the 1970s, with hands-on displays. The third area features the IMAX and 3-D theaters and eight permanent interactive exhibits devoted to space, earth, health, and computers, among other topics. The fourth section features the 1995 CoreStates Science Park, an imaginative urban garden created in collaboration with Philadelphia's Please Touch Museum.

Basic admission to the Franklin Institute exhibitions and Mandell Center is $10 for adults and $8.50 for children. Combined fees for the IMAX theater, 3-D theater, and laser shows run from $3 to $7.50. All-inclusive fees are $14.75 for adults and $12.50 for children. Hours are approximately 9:30 a.m. to 5 p.m. weekdays and 9:30 a.m. to 9 p.m. weekends. The Franklin Institute Science Museum Web site is <www.fi.edu>, and its telephone number is (215) 448-1200. ■

Photo: Top Kat

The frame of Franklin's home is outlined above the ground where it once stood in what is now called Franklin Court near Third and Market streets. Visitors can look through portals to see the privy pits and parts of the original foundation.

LILLY SYMPOS KECK P4C

Pardes Spearheads Search For New Medical Director

APA seeks applicants for its top executive post as current APA Medical Director Steven Mirin, M.D., prepares to resign at the end of 2002.

APA Trustees last month approved a job description for medical director of the Association, and the APA Medical Director Search Committee has established a deadline of May 1 for receipt of curricula vitae of all people who wish to be considered for the position.

The current medical director, Steven Mirin, M.D., has announced his intention to step down by the end of 2002.

Highlights of the job description appear in an advertisement on page 3 and in the April issues of the *American Journal of Psychiatry* and *Psychiatric Services*.

Former APA President Herbert Pardes, M.D., chair of the search committee, told *Psychiatric News* that all correspondence to the committee will be handled confidentially through a private post office box outside of APA (see address at end of article). This will ensure privacy and will protect the integrity of the process.

Members who want to apply for the position should send a curriculum vitae to the post office address rather than corresponding with or calling committee members. The search committee will follow up on all expressions of interest. Members who wish to offer nomination suggestions may send an e-mail message to Carol Lewis, the committee's staff liaison, at clewis@psych.org.

The position description approved by the Board of Trustees describes a "board-certified psychiatrist with clinical experience in direct patient care and supervision, and at least 10 years of progressively increasing responsibility with heath care service delivery, financial and organizational management, government relations, and academic programs."

The description also outlines duties and responsibilities in relation to the Board of Trustees, the Assembly, and the membership of the Association, as well as duties in relation to external organizations and staff.

Professional skills listed in the job description include demonstrated leadership skills, management and financial skills, strong communication and interpersonal skills, effective advocacy, ability to reach out to all constituencies and elements of North American and international psychiatry, experience with volunteer organizations, ability to think strategically, and ability to arbitrate and negotiate with diplomacy.

Among the duties in relation to the Board of Trustees, Assembly, and membership are these:

- Participates in the formulation of all policies and programs of the Association.
- Implements actions of the Board of Trustees; coordinates activities of multiple components; assures that recommendations are transmitted to the Board, Assembly, and Joint Reference Committee for consideration.
- Works with APA officers to facilitate the implementation of their responsibilities and obligations.
- Advises the APA president, who serves as chief executive officer and chief spokesperson of the Association, in designing initiatives and responses to requests and emerging needs; serves as spokesperson for established APA policy.
- Recommends a budget to the Treasurer, Budget Committee, and Board of Trustees; implements sound financial management procedures.
- Regularly informs the officers about the condition and operations of the Association.
- Assumes responsibility for initiating, implementing, and overseeing membership development and retention programs.
- Facilitates active membership involvement and participation in APA's activities.

The Search Committee was appointed in February to identify a successor to Mirin, who has been APA's top staff officer since 1997, when he succeeded Melvin Sabshin, M.D.

The members of the search committee are, in addition to Pardes (chair), Stuart Anfang, M.D., Renee Binder, M.D., Doris Gundersen, M.D., Patrice Harris, M.D., Al Herzog, M.D., Dilip Jeste, M.D., Carolyn Robinowitz, M.D., Jerry Wiener, M.D., and Daniel Winstead, M.D. Richard Harding, M.D., and APA President-elect Paul Appelbaum, M.D., serve ex officio on the committee.

APA members recommended for the search committee's consideration may receive a full copy of the medical director's job description by contacting Carol Lewis at 1400 K Street, N.W., Washington, D.C. 20005, or sending an e-mail to clewis@psych.org. Suggestions may also be sent to this e-mail address. CVs should be sent to APA Medical Director Search Committee, P.O. Box 34557, Washington, D.C. 20043-4557. ■

Court May Reverse on Executing Retarded Persons

The Supreme Court revisits its 1989 ruling in which it said executing prisoners who are mentally retarded does not violate the Constitution.

BY KEN HAUSMAN

Thirteen years ago the U.S. Supreme Court ruled that a convicted criminal's mental retardation does not prevent states from executing that individual. On February 20 the Court heard arguments in a case that may allow it to reverse its earlier decision.

With more Americans expressing opposition to the death penalty as an option for prisoners of extremely low intelligence, the Supreme Court agreed to hear an appeal of a death sentence filed on behalf of a condemned murderer in Virginia who has an IQ of 59. An IQ at this level corresponds to a mental age of 9 to 12 years.

Daryl Atkins was convicted of carjacking and murder, the goal of which was to rob the victim to obtain money with which Atkins could buy beer.

Justices indicated a recognition that public opinion on putting mentally retarded criminals to death appeared to have changed dramatically since they last visited the issue in 1989 in the case *Penry v. Lynaugh*. At that time they found that such executions did not meet the definition of cruel and unusual punishment, which would have rendered them unconstitutional.

There is also growing concern among advocates and others that with an ever-increasing number of people with mental illness and developmental disabilities ending up in the criminal justice system instead of the mental health system, courts could be faced with more opportunities to decide whether such individuals should be put to death.

In Virginia, which is one of the states that allow the death penalty for criminals with mental retardation, lawmakers have deferred debate on whether to rewrite the law to ban such executions until they have a ruling on the *Atkins* case from the Supreme Court.

Eighteen states prohibit executions of mentally retarded individuals. Only two, Georgia and Maryland, did so when the Court handed down its 1989 ruling. In deciding *Penry* in 1989, Justice Sandra Day O'Connor, writing the opinion for the Court's 5-to-4 majority, stated that there was no "national consensus" about whether to bar executions of people who are mentally retarded, and thus the Court did not hold the practice to be a violation of the Eighth Amendment's ban against cruel and unusual punishment. The Court also said, however, that mental retardation should be considered as a mitigating factor when juries debate whether to sentence a criminal to death.

President George W. Bush has said he is opposed to putting people with mental retardation to death. His own state of Texas still permits executions of mentally retarded people. Six such individuals have been executed in the last 20 years, two of them while Bush was governor, according to the Death Penalty Information Center.

The main issue for the Court in the *Atkins* case is whether a national consensus has developed that now views executions of mentally retarded people as cruel and unusual punishment and thus unconstitutional.

The Court had previously decided to hear the appeal of a North Carolina death-row inmate as its vehicle to revisit the issue, but before the Court could hear it, North Carolina passed a law banning executions of people with mental retardation, so it substituted the Virginia case on its docket.

The Death Penalty Information Center's Web site at <www.deathpenaltyinfo.org> has information about cases and state laws concerning execution of mentally retarded persons. Click on "Information Topics" and then "Mental Retardation."

[The case before the Supreme Court is* Atkins v. Virginia *00-8452.] ■

Phones Can Give Wrong Message If Certain Practices Aren't Followed

The old-fashioned telephone, in tandem with newer voicemail systems, can create risk management problems for psychiatrists who aren't careful. This is the conclusion of a two-part series.

BY JACQUELINE MELONAS, J.D., R.N., M.S.

The telephone is an essential tool in modern psychiatric practice, but there are potential liability risks associated with its use. Risk management strategies can be used to prevent and minimize these risks. The best risk management is always to promote effective, satisfying communication between patients and psychiatrists regardless of the means of communication.

Experience has shown that patient dissatisfaction and frustration may be the deciding factor in a patient's decision to sue or file an administrative complaint. Long waits on "hold"; exasperating encounters with answering machines, answering services, or telephone menus; and other barriers that prevent patients from speaking with a human being have the potential to intensify existing dissatisfaction and frustration. Even if formal action is never taken, these types of experiences may cause some patients to seek care elsewhere.

General Precautions

• Do not let problem telephone practices work against the telephone's inherent advantages and convenience.

Take the time to establish and maintain effective and user-friendly telephone policies and procedures. Consider the following risk management strategies to reduce the likelihood of patients' irritation when communicating with you and your practice by telephone.

• Office staff should have specific instructions and training about handling calls.

Make sure that office staff know how to treat callers courteously and professionally, how to minimize the time callers spend on hold, and the types of calls that should be directed to you (or another clinician) immediately.

• Your answering service should meet the same high-quality service requirements that you expect of your office staff in handling and triaging calls.

Periodically call in to the answering service to find out how the operators respond to and manage calls.

• Periodically assess your telephone system and protocols.

Automated Telephone Systems

• If you use an automated telephone system, review and approve of the messages placed on the answering machine.

Occasionally dial into your office, listen to the recording, and evaluate how it sounds to patients. Is it sending the intended message—both explicitly and implicitly?

• Avoid lengthy and confusing telephone menus.

Telephone menus that are long and complicated may confuse and frustrate patients. Listen to the menu and evaluate it. For example, how would a patient in crisis or an impaired patient perceive the menu choices? Consider having others evaluate your menu and give feedback.

• Answering machines are subject to malfunction, power failures, and so on. Check the operation of your system regularly and have a back-up plan.

• Avoid directions that require a patient to hang up and call another number.

Unfortunately, this is sometimes the only option available for calling an emergency number or for contacting a covering physician. In that case, make sure that the instructions are as clear and simple as possible.

• If at all possible, give callers the option to talk to a live person or to receive a prompt return call.

• Provide information about how often messages are checked and when callers can expect a response.

For example, if a patient calls on Friday afternoon, can the patient expect a call back that day or will he or she need to wait until Monday? This type of information allows patients to make decisions about what alternative actions they may need to take.

• Make sure patients can access after-hours coverage, when necessary.

You can use either a mechanical answering system or an answering service. A mechanical system can instruct callers about how to contact the covering psychiatrist or automatically page him or her when messages are left. Any system in which you have to check messages every few hours around the clock is unrealistic and, probably, unsatisfactory.

Section 1-AA of the APA's "*Opinions of the Ethics Committee on the Principles of Medical Ethics, With Annotations Especially Applicable to Psychiatry" (2001 ed.)* provides the following:

Question: One of our members is concerned that psychiatrists in this area do not routinely check in with their answering machines after hours, leave no number where they may be reached, or leave a message for patients to contact the local emergency room in case of emergency.

Answer: Is this member's concern about the ethics of these psychiatrists warranted? Yes. Ethical psychiatrists are obliged to render competent care to their patients. That competent care would include either being available for emergencies at all times or making appropriate arrangements. Certainly, a message telling patients to call an emergency room is not adequate coverage.

*see **Phones** on page 24*

Ms. Melonas is vice president of risk management for Professional Risk Management Services Inc., the manager of the Psychiatrists' Program, the APA-endorsed professional liability insurance program.

Drug Costs' Upward Spiral Fueled by Multiple Factors

The link between marketing costs and the increase in expenditures on prescription drugs is much more complicated and interesting than depicted in the popular press.

BY KATE MULLIGAN

State officials sounded a note of desperation about the rising costs of health care at the winter meeting of the National Governors Association, according to the *New York Times* (February 25, 2002).

The principal culprit? Spending on prescription drugs through the Medicaid program. The response in more than 40 states has been to try to find legislative and other remedies to stem the financial hemorrhaging (*Psychiatric News*, January 18; February 1).

In the private sector, employers are turning to a three-tier system of providing prescription-drug benefits and to larger copays in their own efforts to contain costs (*Psychiatric News*, October 19, 2001; January 18).

Ernst R. Berndt, Ph.D., a professor of applied economics at the Massachusetts Institute of Technology's Sloan School of Management, wrote that utilization, rather than price, has been the primary driver of increased pharmaceutical spending.

That conclusion appears in the article "The U.S. Pharmaceutical Industry: Why Major Growth in Times of Cost Containment," first published in *Health Affairs* in the March/April 2001 issue and reprinted in "The Value of Rx Innovation: A Primer From *Health Affairs*" last year.

Berndt identified four factors that increased utilization, even though cost-containment measures were being applied in other aspects of health care.

In an interview with *Psychiatric News*, he speculated about the future role of those factors and their applicability to drugs used to treat mental illness.

Below Radar Range

Berndt relied on the common-sense reasoning of a 19th-century economist for his first factor. Alfred Marshall proposed the idea that cost cutters will likely focus on big-ticket items, rather than on goods or services that make up a smaller part of a total budget.

From 1960 through 1998, hospital care and physician services together made up more than 50 percent of health care expenditures, with prescription-drug costs actually declining as a percentage from 10.0 percent in 1960 to 7.9 percent in 1998, the last year for which Berndt had data.

Thus, according to Berndt, prescription drugs were not on the radar screen of cost cutters until recently because of their relative unimportance in the total scheme of health care costs.

But, he added, data reported in the January/February issue of *Health Affairs* show a 17.3 percent increase in prescription-drug spending for 2000, compared with a 6.9 percent increase overall in national health expenditures. So, it's not surprising that both employers and governmental officials are taking aim at a now highly visible target.

Unintended Consequences

Berndt noted that the thriving economy contributed enormously to the greater utilization of prescription drugs because employers were willing to offer attractive benefits to retain employees. In 1965 private insurance covered 3.5 percent of prescription-drug spending; in 1990, the figure was 34.3 percent, and in 1998, 52.7 percent.

Information technology played a key role by making insurance transactions more convenient and less costly. Until the 1990s consumers with third-party insurance typically paid the full cost of drugs and then submitted receipts for reimbursement. Today, payment is handled electronically.

These electronic transactions can be monitored easily by pharmaceutical benefit managers.

Researchers find, according to Berndt, that per capita drug use is strongly associated with the extent of drug coverage and with amounts required for copayments.

Berndt said, "With the economy weakening and employers increasing copayments, expanded drug coverage in the private sector does not appear to be a likely source of greater utilization in the near future."

With both Republicans and Democrats pushing for some form of prescription-drug benefit for the Medicare-age population, however, expanded drug coverage in the public sector likely will promote greater utilization.

Successful New Products

Using data from IMS Health, a for-profit provider of pharmaceutical information, Berndt found that since 1997 about 46 percent, on average, of drug-spending growth is attributable to new pharmaceutical products, about 32 percent to volume and mix changes involving older drugs, and 22 percent to the price growth of older drugs.

For his analysis, he accepted the IMS Health definition of "new product" as any product having a new National Drug Classification code that was launched during the 12 months ending with the last calendar quarter.

In 2001 the pharmaceutical industry spent an estimated $30.3 billion in drug development, a 16.6 percent increase over research and development expenditures during 2000 (see story on page 8). Of that amount, $7.3 billion was spent on central nervous system drugs, the great majority of which are directed to mental disorders.

The impact of marketing on the cost of drugs is much more complicated than is suggested by stories in the popular press about the pharmaceutical industry's courting of the medical profession, according to Berndt.

Nontraditional Marketing

He believes that research and diffusion of information that informs consideration of new diagnostic criteria and treatment guidelines are "nontraditional" forms of marketing that benefit patients and also increase the use of pharmaceuticals.

Even "traditional" marketing efforts must be considered in light of the nature of pharmaceuticals. Berndt classifies prescription drugs as "experience goods," as opposed to "search goods." The former must be experienced for a consumer to be persuaded of their value, because their effect is unknown and can be idiosyncratic. The contrast, in everyday terms, is between a lipstick and a pencil. Advertising-to-sales ratios tend to be higher for experience goods, since a consumer must be persuaded to try the good, as opposed to merely finding a good that meets a felt need.

Berndt estimated that in 1999 pharmaceutical companies spent $13.9 billion on marketing, which yielded a marketing-to-sales ratio of 12.3 percent. The ratio is higher than for a company selling search goods (Sony at 4.7 percent), but lower than for another company selling experience goods (McDonald's at 21.1 percent).

The future, according to Berndt, promises more aggressive marketing efforts. New products will continue to be launched. Many of these products will be competing with existing products. Consumers, as well as the medical profession, are demanding more information about the effects and efficacy of pharmaceuticals. ■

Evidence Builds for Prefrontal Cortex Abnormality in Conduct Disorder

A new study adds to the growing volume of evidence that the prefrontal cortex is implicated in criminal and precriminal behavior.

BY JOAN AREHART-TREICHEL

It's looking more and more as though the prefrontal cortex—that region of the brain above the eyes and behind the forehead involved in judgment, planning, and decision making—is not working right in criminals and potential criminals. For instance, Adrian Raine, Ph.D., a professor of psychology at the University of Southern California, found that prefrontal cortex volume was significantly smaller in violent, antisocial men than in controls (*Psychiatric News*, March 3, 2000).

And now yet another investigation implicating the prefrontal cortex with criminality has been conducted by Lance Bauer, Ph.D., and Victor Hesselbrock, Ph.D., professors of psychiatry at the University of Connecticut School of Medicine in Farmington. The results were published in the October 15, 2001, *Biological Psychiatry*.

Bauer and Hesselbrock selected 158 boys and girls aged 14 to 20 years as their subjects. Half had exhibited conduct disorder according to *DSM-III-R* criteria, and half had not. They placed 32 electrodes in various locations on their subjects' scalps. The subjects were then given a memory task—they were asked to judge whether various stimuli had been presented. While they were engaging in the memory task, the electrodes on their scalps were recording brain-wave responses in various areas of their brains. Bauer and Hesselbrock measured these brain-wave responses.

Bauer and Hesselbrock then compared brain-wave responses of the subjects who had conduct disorder with those of subjects who had not. They found that subjects without the disorder had exhibited robust brain-wave responses in the prefrontal cortex during the memory task, whereas subjects with the disorder did not. There were no significant differences in brain-wave responses between the two groups of subjects in brain areas other than the prefrontal cortex. Also of interest, the results localized the brain-wave deficits to the left prefrontal cortex. However, a similar experiment conducted by the researchers in 1999 localized the brain-wave deficits to the right prefrontal cortex.

Bauer and Hesselbrock concluded that "the neurophysiologic substrate underlying conduct-problem behaviors is bilaterally represented within the prefrontal cortex."

Psychiatric News asked Peter Finn, Ph.D., a psychologist at Indiana University doing similar kinds of research, for his comments on the study.

"I have high regard for Drs. Bauer and Hesselbrock," he said. "They are well known in the field of the psychobiological bases of conduct problems and social pathology, and their work is very rigorous."

As for this particular study, Finn said, he believes that its strength lies in the fact that Bauer and Hesselbrock took a topographical approach to identifying the biological origins of prefrontal cortex abnormalities in youngsters with conduct problems.

"The fact that the study had a pretty large sample size and was collected for the most part from the community was also important," he added. "It was a sample that you could be confident was representative to some degree of the individuals who have these kinds of conduct problems."

This study was supported in part by a Public Health Service grant. ■

legal news

Phones

continued from page 21

Even in rather stable practices, including analytic practices with relatively stable patients, emergencies do arise. Care must be taken that, if and when such emergencies do arise, the patient is not abandoned (September 1993).

• Carefully consider what information/directions will be provided for patients who have an emergency.

It seems obvious, but with an automated system, it is important to provide instructions that are as clear and straightforward as possible for patients who are in crisis or experiencing an emergency situation.

• Carefully consider how patients with an urgent, but not an emergency, situation should be directed.

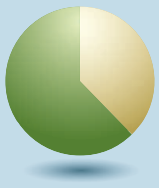
Sometimes a patient may be unsure about whether his or her particular situation constitutes an emergency and, thus, may be hesitant to go to a hospital emergency department or call 911. This may cause a delay in necessary treatment. In contrast, patients who do not have an urgent or emergency situation sometimes misuse the emergency contact procedure because they want immediate access to the psychiatrist. These types of problems can be reduced, although never eliminated, through patient education. Include information about what to do in an emergency in written information or office brochures for patients. Some practices include emergency procedures in the "Consent to Treatment" forms signed by patients. A discussion about what to do if the patient is experiencing a crisis or an emergency should be part of the ongoing communication between the patient and psychiatrist. Re-evaluate your answering system if patients continue to misuse emergency numbers and procedures when there is no emergency. They could be telling you they are frustrated in their attempts to reach you through regular telephone calls to your office, answering service, or automated answering system. ■

APA's 2002 election results

President-Elect:

Marcia Kraft Goin, M.D.
5,863
62.3%

Sidney H. Weissman, M.D.
3,555
37.7%

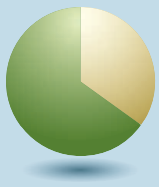


Total votes cast: 9,418

Vice President:

Steven S. Sharfstein, M.D.
6,029
65.1%

Barry F. Chaitin, M.D.
3,231
34.9%

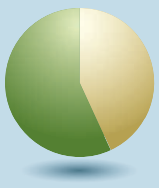


Total votes cast: 9,260

Treasurer:

Carol A. Bernstein, M.D.
5,227
56.9%

Michael J. Vergare, M.D.
3,964
43.1%

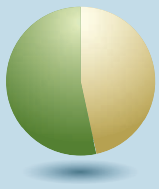


Total votes cast: 9,191

Trustee-At-Large:

David Fassler, M.D.
4,766
53.4%

Herbert S. Peyser, M.D.
4,167
46.6%

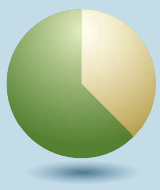


Total votes cast: 8,933

Area 2 Trustee:

Ann Marie T. Sullivan, M.D.
804
62.5%

Richard I. Altesman, M.D.
483
37.5%

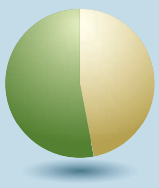


Total votes cast: 1,287

Area 5 Trustee:

Jack W. Bonner III, M.D.
962
53.0%

Anita S. Everett, M.D.
842
47.0%

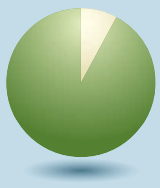


Total votes cast: 1,814

Amendment to Bylaws:

In Favor
8,020
92.1%

Opposed
691
7.9%



Total votes cast: 8,711

Proposed amendment to Chapter 11.2:
The change would have required Assembly ratification of Board-approved amendments to the bylaws.

Out of 30,865 eligible voters, 9,564 returned marked ballots, or only 31.0%. Bylaws Section 11.4 states: "Approval by a majority of at least 33 1/3% of the eligible voting members of the Association shall be required for adoption of the proposed amendment." Therefore, since the amendment failed to achieve the votes of 33 1/3% of the eligible voting members, the amendment failed to pass.

Member-in-Training Trustee-Elect:

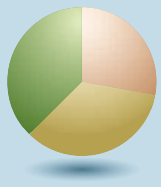
STEP 1:

Count first-choice votes for each candidate.

Angela D. Harper, M.D.
291
37.5%

Sonia G. Patel, M.D.
268
34.6%

William C. Wood, M.D.
216
27.9%



Total votes cast: 775

STEP 2:

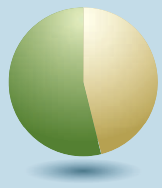
No candidate has a majority of first-choice votes. The candidate with the lowest number of first-choice votes (Wood) is eliminated, and his ballots are redistributed to the remaining candidates on the basis of second choice.

For ballots where the first choice was cast for William C. Wood, M.D.:
Second-choice votes were distributed as follows:
89 votes for Angela D. Harper, M.D.
57 votes for Sonia G. Patel, M.D.

New Totals:

Angela D. Harper, M.D.
291+89 = 380
53.9%

Sonia G. Patel, M.D.
268+57 = 325
46.1%



Total votes cast: 705

LILLY SYMPOS SHELTON
P4C

Many 'Preemies' Don't Outgrow Cognitive, Other Problems

While premature babies do better on a number of measures than expected, new evidence indicates that some of these children have problems that follow them into adulthood.

BY MARK MORAN

It garnered front-page headlines from the *New York Times* to the *Cleveland Plain Dealer*. And depending on where it appeared, the story about research on long-term outcome of prematurely born babies could be read in variable light: either as encouraging evidence that they do better than expected, or as a sobering reminder that the developmental problems experienced by "preemies" persist into adulthood.

In fact, the study—which appeared in the January 17 edition of the *New England Journal of Medicine*—suggests both.

Led by Maureen Hack, M.B., of the department of pediatrics at Case Western Reserve University School of Medicine and the University Hospitals of Cleveland, the study compared 242 survivors among low-birth-weight babies born between 1977 and 1979 with 233 controls with normal birth weights from the same population in Cleveland.

On the sobering side, the study found that fewer individuals in the preemie group had graduated from high school and that they had lower academic achievement, higher rates of neurosensory impairments, and subnormal height. Very-low-birth-weight individuals had significantly lower mean IQ scores than controls (87 versus 92), and had a higher frequency of subnormal IQ (defined as lower than 70) and borderline IQ (70 to 84). Fifty-one percent of the very-low-birth-weight individuals had an IQ in the normal range (equal to or greater than 85), compared with 67 percent of the controls. These differences remained significant when the comparisons were restricted to participants without neurosensory impairment, the researchers stated.

On the encouraging side, the study found that the preemie group reported less alcohol and drug use, had less contact with the police, and had lower rates of sexual activity and pregnancy at 20 years of age.

Psychiatrists who addressed the study's implications for behavioral and mental health tended to emphasize the hopeful message in the findings, while underscoring their preliminary nature.

"When you see these kids very young, you tend to wonder what the course of their life will be like," said Marilyn Benoit, M.D., president of the American Academy of Child and Adolescent Psychiatry and program director for child psychiatric services at Howard University Hospital in Washington, D.C. "But the core message from this study is a sense of hope."

The finding that developmental delays persist into adulthood is "not at all surprising," Benoit told *Psychiatric News*. "What was unexpected is their relative success despite their difficulties. When recognized early and treated with appropriate and sustained interventions that involve the parent, these kids can have a very decent life."

Noting the relatively poor performance of controls as well—and the fact that the study population was drawn from a lower socioeconomic cohort in Cleveland—Benoit also emphasized the potent effect of poverty on outcome for all children.

"The good news we can tell parents is that there are many children who are born at very low birth weight who appear to do quite well," said David Fassler, M.D., chair of APA's Council on Children, Adolescents, and Their Families. "That is an important and encouraging message. Now we need to figure out which kids are at relatively greater risk and find interventions that are effective for those children."

But Fassler, noting the varying treatments the study received in the popular press, suggested it might reveal as much about the variations in spin to which research may be subject when a difficult study about a challenging subject of wide public interest turns up differing findings.

Fassler said the relatively small sample size and improvements in neonatal care since the time when the preemies in the study were born make it difficult to draw firm conclusions one way or the other.

"It raises a lot of interesting questions, but we should consider the findings preliminary," he said. "The study is interesting and useful, but it is not yet specific enough for us to make clinical predictions for a particular child."

Fassler noted that of an initial cohort of 490 babies with very low birth weight (those weighing less than 1500 grams), only 316 (64 percent) survived to the second year. An additional four children died before age 20, and 70 were not studied for a variety of reasons.

"We need to be careful that we are not looking at a somewhat skewed sample," said Fassler. "In the next phase of their research, the authors will look at specific parameters to help parents and physicians use this information in a more meaningful way. For example, is the outcome different based on the level of the child's impairment?"

In an interview with *Psychiatric News*, lead researcher Hack said that in subsequent research using the same population, she hopes to employ in-depth psychiatric interviews to answer more fully questions about behavioral and mental health, as well as overall functioning.

Of importance to psychiatrists, Hack said the *NEJM* report did hint at higher rates of bipolar disorder among the preemies

see ***Preemies*** *on page 40*

SSRI Improves Behavior Symptoms In Demented Elderly Patients

The SSRI citalopram may be a safer alternative to antipsychotic therapy in treating the behavioral disturbances common in elderly demented patients.

BY JIM ROSACK

Elderly demented patients who experience behavioral disturbances may be effectively treated with the selective serotonin reuptake inhibitor citalopram, according to new research. If the results hold up in future research, the highly selective SSRI, well known for its benign interaction and side-effect profiles, may offer patients an equally effective, but far safer, alternative to conventional treatment with antipsychotic medications.

Psychotic and behavioral disturbances such as hallucinations, delusions, restlessness, disruptive vocalizations, and aggression are often among the most distressing aspects of dementia, including Alzheimer's disease, and are frequently cited as the reason for families to admit relatives to long-term-care facilities, according to Bruce Pollock, M.D., Ph.D., the study's principal investigator and his coauthor, Jules Rosen, M.D.

Pollock's team of researchers randomly assigned more than 80 hospitalized patients with at least one moderate-to-severe target symptom of behavioral disturbance to citalopram; the conventional neuroleptic, perphenazine; or placebo, for up to 17 days while hospitalized.

Only patients receiving citalopram showed significantly greater improvement in their total Neurobehavioral Rating Scale score as well as in the scores for the agitation/aggression and lability/tension factors.

The study, funded through grants from the National Institute of Mental Health, was reported in the March issue of the *American Journal of Psychiatry*.

Pollock, director of the Geriatric Psychopharmacology Program at the University of Pittsburgh School of Medicine and Western Psychiatric Institute and Clinic, became interested in using citalopram for behavioral disturbances in the early 1990s when Scandinavian researchers published reports using the drug—which at the time was not yet approved in the U.S.—to attempt to alleviate cognitive decline in patients with Alzheimer's disease.

"They had done some neurochemical work on postmortem brains and felt there was definitely evidence of deficit in serotonin in Alzheimer's disease patients," Pollock told *Psychiatric News*.

Although the Scandinavian researchers found no improvement in cognitive function with citalopram, they noted that family members of patients in the study receiving the drug requested that their relative remain on the medication after the study ended. When asked why, the families consistently remarked that the patients' behavior seemed to have improved on the drug.

Pollock obtained approval from the FDA to use citalopram as an investigational new drug. He believed there was some evidence at the time to link serotonin dysfunction to aggression and impulsive disorders.

"Where the billions of dollars have been invested in the pharmaceutical industry has been in trying to improve treatment of the cognitive aspects of Alzheimer's disease," Pollock said. "No one in industry would even look at this proposal, so it was vitally important that NIMH funded this study."

Rosen, a professor of psychiatry and director of the geriatric psychiatry fellowship at the University of Pittsburgh, saw the great need from the clinical point of view. He had seen countless numbers of patients on haloperidol, perphenazine, or another sedating medication and knew that it was not the best medicine.

"We all know that the data supporting the use of conventional neuroleptics [like haloperidol or perphenazine] to treat behavioral disturbances are quite marginal at best," he told *Psychiatric News*. "And I was looking at these people and was thinking, What am I really treating? And I came to realize that agitation is really a constellation of other different symptoms. You have people who are really dysphoric and truly miserable, you have people who are very anxious, you have people who are obsessive or impulsive. So I started trying to understand these patients less by throwing them into the grab-bag of agitation, and more as to what we really needed to be treating in these individuals. And SSRIs kept jumping out at me."

The team is now working on a second NIMH-funded study, comparing citalopram with risperidone.

"This study will take the scientific exploration of the issue to a new level," Rosen commented. "The idea is not simply to get people well in the hospital and then discharge them but to extend that and see the interaction between the drug's effects and the environment. By following people back into the nursing home for up to three months, we are really trying to determine if there is a differential [between the two drugs]."

Both Rosen and Pollock believe that the SSRI and the atypical antipsychotic risperidone will be effective in the new study. What they would like to see is whether one or the other helps patients adjust better to the nursing-home environment. Both also stressed that they did not want to overstate the first study's results, noting that it involved a relatively small sample, over a short period.

"What we did show," Pollock concluded, "was a positive effect of citalopram that, contrary to what we would have expected, helped to alleviate not just the agitation, but the psychotic symptoms in Alzheimer's disease, a lot of which were visual hallucinations."

The study, "Comparison of Citalopram, Perphenazine, and Placebo for the Acute Treatment of Psychosis and Behavioral Disturbances in Hospitalized, Demented Patients," is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/159/3/460>. ■

Antidepressants Reduce Hot Flashes, May Be Estrogen Alternative

Researchers have confirmed that antidepressants can be an effective treatment for particular symptoms of menopause. The finding is especially helpful for women who can't or don't want to take estrogen.

BY JIM ROSACK

Women who are experiencing hot flashes associated with menopause or induced by treatment for breast cancer may now have an effective, nonhormonal treatment, according to researchers at the Mayo Clinic in Rochester, Minn. A pair of recent Mayo studies have confirmed earlier reports that antidepressants are safe and effective in reducing both the frequency and severity of hot flashes by approximately 60 percent.

A follow-up study of more than 100 postmenopausal women, most being treated for breast cancer, showed that venlafaxine (Effexor), a combined serotonin/norepinephrine reuptake inhibitor, reduces hot-flash symptoms over an eight-week period, twice the length of time reported in a previous Mayo study involving nearly 200 women.

The venlafaxine study, which appeared in the February issue of the journal, *Oncology Nursing Forum*, furthers evidence that the antidepressant is a safe and effective treatment in place of the traditional prescription for estrogen-based hormone replacement therapy.

The study was partially funded by Pfizer Inc., the maker of Effexor.

In women who are being treated for breast cancer, estrogen therapy is contraindicated, because certain types of breast cancers are estrogen dependent. Increasing levels of estrogen is thought to induce these specific types of cancer to grow at accelerated rates and potentially to become more aggressively invasive.

The report on venlafaxine builds on previous studies of the use of paroxetine (Paxil) in treating hot flashes. In those previous studies, as well as the current report, researchers found that the medication seemed to affect patients' mood as well.

A "notable finding," the authors wrote, relates to responses given by women on a questionnaire relating to side effects experienced during the study. "Several women reported being able to 'handle stress better' and 'think more clearly.' " Other patients noted that they felt better than ever, or had more energy.

"This finding," the authors added, "makes treatment with venlafaxine a particularly positive intervention, one that perhaps has the potential to target additional symptoms in menopause related to hot flashes."

Previous studies have indicated that about 20 percent to 30 percent of women with cancer suffer from comorbid depression, Donna Stewart, M.D., professor of psychiatry and chair of women's health at the University of Toronto, told *Psychiatric News*. "It's important to note, however," Stewart said, "that not all women who have cancer have affective disorders, and perimenopausal women on the whole have not been shown to have any increased incidence of depression either."

Stewart, who is chair of APA's Committee on Women, noted that it could be possible that women who have previously had major depression, postpartum depression, or premenstrual dysphoric disorder–like symptoms might have a predisposition to developing depressive symptoms during or after menopause; however, research has not shown that so far. She also speculated that the comments made by patients in the venlafaxine study may have simply "picked up on that 20 to 30 percent" of women who are being treated for cancer and have depressive symptoms.

Charles Loprinzi, M.D., a Mayo Clinic oncologist who led the research team, said that at a dose of 75 mg a day, extended-release venlafaxine not only reduced the frequency of hot flashes by 60 percent on average, it also seemed to reduce the severity of the remaining hot flashes that women did experience.

In the team's second report, which appeared in the March 15 issue of the *Journal of Clinical Oncology*, they present data on 81 women undergoing treatment for breast cancer and reported "significant and bothersome" hot flashes that had occurred on average at least twice a day. The women were treated with four weeks of fluoxetine (Prozac). Again, results indicated that the SSRI reduced both the severity and frequency of hot flashes overall. However, the response with fluoxetine was not as robust as that seen with venlafaxine.

The fluoxetine study was partially funded by Prozac manufacturer Eli Lilly & Co.

The Mayo Clinic team believes the ability of the antidepressant to alleviate the symptoms of hot flashes is tied to its modulation of serotonin. This would be consistent, they wrote, with the existing evidence that venlafaxine's actions are mainly related to serotonin and not norepinephrine at lower doses like those used in the current study, and in light of the evidence already gathered with paroxetine, an SSRI.

Loprinzi, a coauthor of both the venlafaxine and fluoxetine reports, remarked in a prepared statement announcing the results of the second study, "The clear message is that now many women with breast cancer do not have to suffer with their hot flashes and that women who want a nonestrogenic choice of treatment now have one."

"Venlafaxine for the Control of Hot Flashes: Results of a Longitudinal Continuation Study" can be accessed on the Web at <www.ons.org/xp6/ONS/Library.xml> by clicking on* Oncology Nursing Forum. *An abstract of "Phase III Evaluation of Fluoxetine for Treatment of Hot Flashes" can be accessed at <www.jco.org/> by clicking on "Search JCO" and entering the author's name. ■

Guide Helps Clinicians Manage MH Problems

Pediatricians and other primary care professionals now have an in-depth resource to promote children's mental health.

BY CHRISTINE LEHMANN

Parents are more likely to initially raise mental health concerns about their children with pediatricians and other primary health care professionals than to seek out mental health specialists. Yet many primary care professionals are not trained to recognize the range of psychiatric problems that can arise. A new mental health practice guide from Bright Futures could boost their diagnostic skills and confidence in managing mental illnesses in children.

Michael Jellinek, M.D.: "Our intent was to develop a practical guide that focused on how the child functions at each developmental stage."

Bright Futures is a partnership between the federal Child and Maternal Health Bureau and the National Center for Education in Maternal and Child Health at Georgetown University. "Its federal mandate is to promote the health and well-being of children, families, and communities," according to the Bright Futures practice guide.

The "Bright Futures Mental Health Practice Guide and Tool Kit" will be distributed to the more than 50 organizations that supported it, including the American Medical Association, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American Academy of Family Physicians, and American Academy of Physician Assistants.

Previous Bright Futures guides have addressed oral health, physical activity, and nutrition. The guides emphasize interdisciplinary partnerships and partnerships between health professionals and families, schools, and communities.

The 371-page guide is divided into two main sections made up of chapters on child mental health development and common disorders among children and adolescents.

Michael Jellinek, M.D., chair of the panel of experts that produced the guide, said at a Bright Futures conference last month, "We wanted a practical guide that focused on how well the child functions individually, in the family, with friends, and in the community at each developmental stage."

Each chapter is divided into the four areas of functioning that Jellinek noted and includes checklists at the end for health professionals to evaluate the child's development.

The guide's table of contents also lists helpful tools for health professionals and families under each developmental chapter. The tools are found in the companion Mental Health Tool Kit and can be photocopied for further distribution, such as to parents.

For example, under "Self-Esteem" in the chapter on early childhood, among the tools included for health professionals are "The Pediatric Intake Form" and for families are "Stimulating Environments," "Safe, Quality Child Care," and "Communicating With Children."

Health care professionals can use the referral form in the tool kit to refer patients to mental health specialists. Another practical tool is a documentation form for reimbursement that can accompany insurance claims.

A National Agenda

The Bright Futures conference and new practice guide on children's mental health build on the efforts of former Surgeon General David Satcher, M.D., to raise public awareness of mental disorders in adults and children. A specific goal mentioned in the national action agenda released last January that resulted from the 2000 Conference on Children's Mental Health called for educating primary care providers and families to recognize the warning signs of mental illness in children (*Psychiatric News*, February 2, 2001).

More recently the Office of the Surgeon General (OSG) has been combining the children's mental health goals and objectives with the recommendations from another report, "The Integration of Mental Health Services and Primary Health Care," in the areas of practice, finance, and research, according to Eve Moscicki, senior advisor to the surgeon general and chair of the working group that developed the national action agenda on children's mental health. When the results of that work will be released is not yet known, she said.

The OSG is also developing a set of early warning signs to identify when children need further mental health assessment or referral, as well as an initiative on mental health services in the schools, said Moscicki.

APA has long recognized that primary care professionals play a critical role in identifying psychiatric disorders in both adults and children. APA collaborated with primary care physician organizations to produce the *DSM-IV-PC* in 1995.

The American Academy of Pediatrics (AAP) launched a parallel effort with APA and the American Academy of Child and Adolescent Psychiatry and other organizations to produce the *DSM-PC Child and Adolescent Version* in 1996. The reasoning behind producing this volume was that children are cared for primarily by pediatricians and family practitioners and that clinicians encounter a wide range of psychosocial problems that may not meet full *DSM-IV* criteria for a diagnosis but still require intervention, according to the AAP.

The Bright Futures guide incorporates codes for mental disorders from APA's *DSM-IV-TR* and codes for psychosocial problem from the *DSM-PC Child and Adolescent Version*.

Barriers Remain

According to Barbara Howard, M.D., a behavioral pediatrician and panelist at the Bright Futures conference, treatment reimbursement remains a problem.

"Insurance companies tend not to reimburse pediatricians who diagnose and treat disorders within the *DSM* 300 codes, including autism, depression, anxiety disorders, and attention-deficit/hyperactivity disorder. The AAP plans to undertake a state-by-state effort to talk to insurance companies about reversing that practice, starting with ADHD," said Howard.

Kelleher told *Psychiatric News* that "most pediatricians believe they will lose money if they start diagnosing and treating mental health problems."

Managed care has contributed to the problem by carving out mental health networks from primary care networks. "It is much harder for primary care professionals to be reimbursed for mental health services in carveouts than in integrated staff-model HMOs," said Kelleher.

Moreover, primary care professionals spend an average of only 13 to 16 minutes with each patient, and each patient has an average of six problems to discuss, according to the OSG report titled "The Integration of Mental Health Services and Primary Health Care."

Online Versions?

Howard and Kelleher have developed interactive computer systems for primary care settings incorporating some of the materials from the Bright Futures mental health guide. Howard's system is known as the Child Health and Development Interactive System (CHADIS), and Kelleher's is EnterVue.

Both claim that their online interactive versions are more efficient than the pencil-and-paper guides because they provide "real-time" information to clinicians and parents. Another advantage is they can be linked to patients' electronic medical records, diagnostic codes, and Internet resources and used for research. These products are being tested and may be released late this year or next year.

The "Bright Futures Mental Health Practice Guide and Toolkit" are posted on the Web at <www.brightfutures.org/mentalhealth/index.html>. The two-volume set can be ordered at the Web site for $58 plus shipping and handling. ■

Criteria Differentiate Alzheimer's Depression From Other Types

Diagnostic criteria for the depression that often accompanies Alzheimer's disease have been devised by a team of national authorities.

BY JOAN AREHART-TREICHEL

The depression that sometimes accompanies Alzheimer's disease has long been problematic from a diagnostic viewpoint. It doesn't seem to fit the criteria for *DSM-IV* major depressive disorder, yet the *DSM-IV* doesn't contain criteria for Alzheimer's depression per se.

So some authorities in the field of Alzheimer's depression decided to see whether they might be able to reach a consensus on how Alzheimer's depression differs from major depression and to draw up provisional diagnostic criteria for the former. They have now managed to do so, they reported in the March-April issue of the *American Journal of Geriatric Psychiatry (AJGP)*.

The authorities include Jason Olin, Ph.D., and Barry Lebowitz, Ph.D., of the National Institute of Mental Health's Adult and Geriatric Treatment and Preventive Interventions Research Branch; Ira Katz, M.D., Ph.D., a professor of psychiatry at the University of Pennsylvania; Barnett Meyers, M.D., a professor of psychiatry at Cornell University; Lon Schneider, M.D., a professor of psychiatry at the University of Southern California; and other experts on the subject who participated in the NIMH Depression of Alzheimer Disease Workshop.

Probably the most striking point that Olin and his coworkers have come to agree on is that the depression that often accompanies Alzheimer's is definitely not the same as major depressive disorder. True, both kinds of depression share a number of symptoms, such as depressed mood, decreased pleasure in response to one's usual activities, disruption in sleep, feelings of worthlessness and guilt, diminished ability to concentrate, suicidal ideation, and so forth. But the withdrawal and social isolation observed in depressed Alzheimer's patients are not the same as those displayed in patients with a major depressive disorder.

As Olin explained to *Psychiatric News*, "The consensus of the group was that the terminology used in *DSM-IV* was not written with consideration of the apathy often seen in Alzheimer's disease. Major depression's criterion is stated as follows: 'Marked diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.' For depression of Alzheimer's disease we state: 'Decreased positive affect or pleasure in response to social contacts and usual activities.' "

Another difference between Alzheimer's depression and major depressive disorder, Olin and his colleagues concurred, is that only three pertinent symptoms need to be present for at least two weeks to constitute a diagnosis, whereas five or more pertinent symptoms must be present for at least two weeks to constitute major depression. The reason, Olin explained, is "that the criteria for major depression set a level of severity that is higher than much of the depression seen in Alzheimer's disease."

For Alzheimer's depression to be diagnosed, the experts agreed, a person must have already been diagnosed with Alzheimer's according to *DSM-IV* criteria.

Who will benefit from these provisional diagnostic criteria? First, scientists researching Alzheimer's depression treatments. "The immediate goal," Olin said, "was to get out to the field a set of standardized criteria so that treatment research could be more easily generated."

Dilip Jeste, M.D., a member of the NIMH Depression of Alzheimer Disease Workshop and editor of *AJGP*, agreed. "Hopefully the criteria will jump-start the field by providing a more consistent target for treatment development."

Alzheimer's patients who suffer from depression will probably also benefit from the provisional criteria. The reason, Jeste explained, is that existing diagnostic criteria for major depression weren't always sensitive enough to detect Alzheimer's depression and therefore led to under-recognition and undertreatment. Olin made a similar comment: "If we only looked at individuals with Alzheimer's disease who met *DSM* criteria for major depression, a substantial group of others would be excluded from possible treatment."

Olin and his team drafted these provisional diagnostic yardsticks for Alzheimer's depression by using methods similar to those used by experts who draft *DSM* diagnoses. For instance, a team of investigators was formed that had expertise in both dementia and late-life-depression research. Before starting the process of criteria development, the team created a Web site that provided for the distribution of review articles. To facilitate discussion, an initial draft of diagnostic criteria was developed by five of the groups in the style of *DSM-IV* major depressive episode. Through a process of conference calls, e-mail discussions, and circulation of multiple drafts, the criteria were finalized.

"I definitely hope that investigators will take advantage of this first step and use the criteria to increase our understanding of the depression found in Alzheimer's disease," Olin said. "For instance, perhaps we will come up with enough evidence to show a causal link between the depression in Alzheimer's and Alzheimer's itself."

The study, "National Institute of Mental Health Provisional Diagnostic Criteria for Depression of Alzheimer's Disease," is posted on the Web at <http://ajgp.psychiatryonline.org> under the "March-April 2002" issue. The journal is published by the American Association for Geriatric Psychiatry. ■

WYETH EFFEXOR
P4C

Candidate Offers Thanks

I would like to use this opportunity to express my appreciation for the support that I received from APA members in the campaign for president-elect. I urge all of my supporters to continue to work with the APA leadership to implement the changes that our Association must undertake. When we started our campaign last September, we argued for an assessment of all aspects of APA's functioning. I am delighted this need has been implemented and that a process is under way to implement reform. We must monitor these steps to ensure that there is input and considered decision making.

The fact that the governor of New Mexico signed a psychologist prescriptive authority act reshapes the agenda that APA must confront in the coming months. We must all work together to develop a meaningful and effective response to this challenge, recognizing that this will be an issue in many states. In our response we must work to ensure that we provide to ourselves and to the public a definition of what a psychiatrist is in terms of knowledge and practice that is clear and operational.

Finally, we must continue to confront the reality of APA and district branch membership loss. To have political power, APA must represent a majority of psychiatrists. We have these numbers today but must act to ensure that we have these numbers tomorrow.

SIDNEY WEISSMAN, M.D.
Chicago, Ill.

PSA on Youth Suicide

The January 18 issue of *Psychiatric News* included an excellent article about the prevention of youth suicide. I would like to let readers know that APA has available an excellent public service announcement, produced by Industrial Light and Magic, the producers of the special effects in "Star Wars," on the subject of adolescent suicide.

A copy of the public service announcement can be obtained from APA's Division of Communications and Marketing for use on television stations and at educational programs. Local organizations can add their own tag lines. It is a powerful and effective 30-second addition to any presentation on the subject. APA's Division of Communications and Marketing can be reached by calling (202) 682-6140.

NADA L. STOTLAND, M.D., M.P.H.
Chicago, Ill.

Dr. Stotland is speaker of the APA Assembly and a member of the Psychiatric News *Editorial Advisory Board. She is also a former chair of APA's Joint Commission on Public Affairs.*

Another Story Shared

I am so proud of the two doctors who speak openly about their ongoing struggle with major mental illness. I am equally pleased you gave their message so much space in the January 18 issue.

I still take 150 mg bupropion tabs, b.i.d., to help me avoid resumption of cigarette smoking and to treat my major depression.

I used to commute to work each day with a good friend, also a psychiatrist. One day I asked his opinion about my puzzlement over why I wanted to take my shotgun, go behind the furnace, and blow my heart out rather than put the barrel in my mouth and blow my brains out. He said, "Jesus Christ, Dick. You're sick!"

I was puzzled but respected his opinion. He patiently took me through the diagnostic manual, and I admitted that I would wake at 2 a.m. and stare at the ceiling. I did not enjoy eating anymore, had stopped a number of activities I used to enjoy, and had been that way for months. Of the three granddaddy antidepressants of that time, I started on imipramine and switched to desipramine in a few months for its less-sedating effect. Sure, psychotherapy was part of the treatment, and it was directed toward the proper use of the meds, changes that needed to be made in life, and other matters. I know from experience the benefit of antidepressants and how unpleasant the earlier ones were to take: dry mouth like you have never had before, constipation requiring regular enemas, and episodic sweating so profuse it runs down your face and soaks through your shirt. Noncompliance is very tempting. Nearly all the meds we prescribe are unpleasant, except the tranquilizers, which may be too much fun for some.

After four years and some necessary changes in my life, I did not require antidepressants again for 20 years until my bypass surgery. I can assure you that major surgery like that and the pain that lasts for months are major stressors to precipitate my Achilles' heel, major depression.

Since these experiences, I have stressed compliance with medication with patients and enlisted the aid of spouses, parents, or friends to that end, using my relationship with my patients to let me enlist their help (relationship therapy). Of course, reality therapy is necessary when certain life changes need to be made no matter how difficult. (I was made to join Al-Anon by my psychiatrist friend, who threatened to never speak to me again if I didn't.)

I am retired now at age 70. Thanks to cardiac surgery and especially cardiac rehab and now living on a farmette and caring for two retired (crippled) horses and their stalls, two barn cats, house cat, and two dogs, I can do physically what I could not do at age 60. Thanks to bupropion, I can avoid smoking cigarettes, and people can enjoy me. Without bupropion, I get so morose people cannot stand me.

God love those two doctors who speak out about their mental illness and use it to help us all.

RICHARD H. PATTERSON, M.D.
Muskego, Wis.

LILY SYMPOS KRATOCHVIL
P4C

continued from page 3

• DGR offered to sponsor witnesses such as psychologists opposed to prescribing and an expert in the Department of Defense program and initiated contact with those potential witnesses to determine availability.

• DGR provided talking points for use in a meeting with the governor, legislative talking points, materials for use in hearings, as well as data refuting proponents' assertions about rural access and provider distribution. DGR staff also developed substitute language that sought to provide for a blue-ribbon commission to study the access-to-care issue in the state.

• APA worked nationally with the AMA, AAFP, the National Alliance for the Mentally Ill (NAMI), and others to urge opposition to the bill. The New Mexico Chapter of AAFP, individual psychologists, physicians, and members of patient advocacy organizations took a position against HB 170. Unfortunately, NAMI-NM retained its position of "neutral" on the bill. DGR continues to encourage ally development with patient groups and other nontraditional allies.

• AMA Executive Vice President Michael Maves, M.D., sent a letter to Gov. Johnson urging a veto of HB 170. Dr. Maves also initiated AMA contact with Republican governors urging them to communicate to Gov. Johnson their concern with the prescribing bill and its potential impact on patients across the country.

• Media activities included providing assistance in drafting and placing op-ed pieces and letters to the editor in major state newspapers. A full-page ad in opposition to the prescribing bill ran in the February 7 edition of the *Santa Fe New Mexican*. DGR also supplied PMANM with guidance on organizing and making visits to newspaper editorial boards.

• A full-page ad urging Gov. Johnson to veto HB 170 ran in the March 1 edition of the *Albuquerque Journal*. The ad, signed by PMANM, the New Mexico chapter of the AAFP, and three psychologist groups, reiterated the health and safety reasons for the governor to veto the bill. The *Journal* subsequently issued a strong editorial opposing the bill and urging Gov. Johnson to veto it.

Despite this defeat, we believe that our experience in New Mexico yields critically important lessons we must take to heart as we grapple with the prescribing debate at the state and federal levels.

• **First, and foremost, psychiatry must not assume that because New Mexico has taken this unwise and dangerous step, the national struggle is effectively over.** Psychologists have relentlessly pursued prescriptive authority for 20 years; APA, in partnership with our DBs/SAs, has argued successfully against these efforts in every case so far except, now, one. While the impact of New Mexico's political decision will take some time to assess, we must not, for the sake of our profession and our patients, abandon this struggle.

• **Rather than despairing, we must renew our commitment to patient safety.** The main lesson of New Mexico is that the prescribing threat is real and must be fought with a renewed vigor, commitment, and tenacity involving not just the national and local APA leadership, but every local psychiatrist.

• **Psychologists will undoubtedly model their national efforts on New Mexico, and their success will undoubtedly spur new efforts.** They will target states with large rural areas that will be portrayed as underserved by psychiatrists. They will seek to exploit states with an independent and "liberal" antiregulation legislature and portray the struggle as pitting altruistic psychologists against rich and lazy psychiatrists who have no interest in delivering services to rural populations. They will also target states where the APA district branch or state association is small in membership number and—however erroneously—perceived by psychologists to be passive and politically inactive.

• **APA must assume that psychologists will continue to be resource rich and totally committed to the struggle.** We must understand the tenacity of local psychologists, who infiltrate patient advocacy groups usually opposed to psychologist prescribing, and the willingness of their national organization, with elected leadership running on a "prescribing platform," to commit years of work and substantial fiscal support to the cause, a cause presented to legislatures with little regard for truth about psychology's self-interest. Let us not forget that last year we identified that psychologists in New Mexico had targeted a state with a major rural mental health access problem and a small APA district branch whose resources were limited and would do so again in 2002.

Psychologists in New Mexico made a political case that local psychiatrists were unable to respond effectively to the perceived rural-access problem, hired the best lobbyists in the state to market their message, prepped the legislature with careful groundwork, demonstrated the political commitment of their membership to the issue and the financial commitment to legislators who supported them, and developed and nurtured personal relationships with key members of the House and Senate, as well as with the governor and his staff. They also effectively neutralized a state medical society that was out of touch with its membership on the prescribing issue and clearly hamstrung with competing interests. We must expect New Mexico to become a template for the rest of the states.

• **District branches and state associations must recognize that New Mexico is not merely a wake-up call, it is a call to action to protect quality patient care.** We are well aware that many of our DBs/SAs have fought the battle successfully for many years,

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Ritalin Suits

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Sandoz Pharmaceuticals in 1997, and the new company took the name Novartis. For decades Ritalin was the only brand of methylphenidate available, though with its patent protection now expired, generic versions of the drug are being manufactured by other companies.

There is a substantial body of scientific data gathered over several decades showing that methylphenidate is an effective treatment for children with ADD or ADHD.

The New Jersey lawsuit, along with the other four, was filed by a parent who had purchased Ritalin after a physician had prescribed it to treat a child diagnosed with ADD or ADHD. In each case the plaintiffs alleged that their suit was a class action and should thus include as additional plaintiffs all the parents in that state who had bought Ritalin that had been prescribed for their children. If certified as a class action, all of the plaintiffs in the class would have been eligible to receive an award for damages if courts had found APA and Novartis guilty of the charges.

The five suits also named as a defendant the advocacy group Children and Adults With Attention Deficit/Hyperactivity Disorder (CHADD). They contended that CHADD received money from Novartis and then conspired with the company to promote the use of Ritalin for children who showed signs of hyperactive behavior.

Last October the judge in the New Jersey suit, Charles Walsh of the Superior Court of New Jersey in Bergen County, ruled that the plaintiffs' claim was insufficiently specific. He gave them 90 days to provide additional material to bolster their charges. The plaintiffs did not follow through on the judge's order, and once the deadline had passed decided to withdraw their complaint.

On learning of the New Jersey plaintiffs' decision to withdraw their suit, APA President Richard Harding, M.D., told *Psychiatric News*, "It is very gratifying to see our judicial system work. Once the facts were brought into the open, there was no doubt about what the eventual outcome of these cases would be."

What is a shame, Harding stressed, "is the enormous waste of resources" that defending itself against these charges cost APA. "While the whole episode was a tremendous waste of time, money, and resources for all the parties, we made it clear from the beginning that APA would do whatever was necessary to defend the scientific basis of diagnostic nomenclature, our profession's freedom to choose appropriate treatments for the patients we serve, and vigorously take on those who oppose these principles in the court and in the court of public opinion.

"The decision of how to treat ADHD is between the parent, patient, and physician, and has no place in the courts."

"The medical profession never stands taller than when it refuses to allow a court to modify or ban a proven medical intervention for a proven medical disorder," he said.

Dorothy Watson, general counsel for Novartis, stated that the failure of all five suits "sends a strong message that the decision of how to treat ADHD is between the parent, patient, and physician and has no place in the courts."

While the withdrawal of the charges appears to signal the end of the New Jersey lawsuit, the fact that the plaintiffs exercised a voluntary withdrawal means that they can renew it at some point. To ensure that does not happen, APA may ask the judge to ignore the voluntary dismissal and rule on the merits of the case. If the judge dismisses the case with prejudice, it would preclude its being brought again.

All of the suits were filed by lawyers who had had considerable success filing nationwide class-action suits against huge corporations, particularly those in the tobacco industry. They, along with some antipsychiatry activists, apparently hoped that these five suits would spawn dozens of others across the United States in a crusade against both organized psychiatry and the pharmaceutical industry. ■

capitol comments

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and that these successful efforts have required many hours of personal involvement by talented and dedicated psychiatrists and outstanding DB/SA executive staff and paid lobbyists, working together where requested with the full staff and financial support of APA. Yet we clearly cannot take any legislature for granted, particularly those in states with large rural areas. Psychologists will hire the best professional lobbyists that money can buy and will be absolutely relentless in their pursuit of prescribing privileges. As we have learned, they will bend the facts to suit their purpose, and they will find legislators who will be receptive to their message. Psychiatrists must be particularly sensitive to the fact that state legislators have experience with similar struggles involving nurses, physician assistants, optometrists, and the like and may well not see prescriptive authority for psychologists as a threat to patient safety.

• **APA must continue as it always has to seek input from local DBs/SAs about what works in their legislatures to counter psychologist-prescribing arguments.** Throughout this long struggle, APA has sought always to be sensitive to the specific needs of local psychiatrists, since they are on the frontlines of the struggle and are clearly best able to determine what works—and what does not work—in their home state. This has been a sound strategy that has enabled APA to concentrate its staff and financial resources in ways that will complement, not compete with, local DB/SA efforts.

• **Finally, local psychiatrists must be prepared to turn out in force as physician lobbyists and active participants in the state legislative and political process.** The APA membership as a whole cannot rely on a very few psychiatrists working together with talented and dedicated DB/SA staff to do all of the work by themselves. The prescribing debate is as much about politics as it is about patient safety, and if local legislators perceive low political risk in voting for psychologist-prescribing authority, APA will surely face additional reversals at the state level. ■

Taxpayers

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Filgrastim is a growth factor and spurs the development of white blood cells. The medication, which is also used in cancer patients, was developed by researchers at Memorial Sloan-Kettering Cancer Center under NIH funding and was licensed to Amgen as well.

Paclitaxel is manufactured by BMS using a patented technology developed by Florida State University using NIH funds.

In addition, NIH has rights to an underlying, related technology that was developed through a direct collaboration between the institutes and BMS. The report noted that the institutes have received "tens of millions of dollars in royalties" from BMS between 1997 and 2000.

Although there has been significant discussion in recent years about taxpayers' investment in NIH research—the institutes received a total of $20.3 billion in tax support for Fiscal 2001—it has been difficult to gauge any "return on investment" because record keeping had not been developed to track technology, drugs, or devices that were developed due to specific NIH funding.

Difficulties in tracking development, according to the report, were noted in four areas. First, technology developed in basic research laboratories is nascent by its very nature, requiring extensive further development. Second, not all technologies that arise from NIH funding lead to the development of a therapeutic drug. Third, the likelihood that a new compound, however promising, will actually reach the market is extremely low. And fourth, the time lag between the actual award of an NIH grant and any product that may reach the market is likely to occur "on average eight to 12 years after a license is signed, and a license offers no guarantee that a product will ever reach the market."

Because it is not easy to cross-reference NIH grants and contracts that funded inventions with any patents or licenses attached to their final products, NIH will implement new procedures to allow accurate and timely tracking, according to the report.

Under the new plan, NIH grantees and contractors will now be required to report directly to the institutes the name, trademark, or other appropriate identifiers of a therapeutic product that was developed through NIH-funded research. This information will be compiled into a publicly available Web-based database.

"The availability of these data will make the research discovery and development process transparent," the report said, and "as a result, it will permit the tracking of a drug's technological pedigree and serve as a resource for the public."

The report concluded that, although difficult to document, the American public has benefited greatly from its tax-based investment in research. In fact, the report estimated that the gains inherent to public health that might be attributable directly to institute-funded research are certainly many times the annual appropriation of tax-funded dollars.

The report, "A Plan to Ensure Taxpayers' Interests Are Protected," is posted on the Web at <www.nih.gov/news/070101wyden.htm>. ■

Proposed Budget

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such an assurance is legally impossible, the companies were exiting because they could not afford to participate at current reimbursement rates.

Thompson said, "One hundred and ninety billion dollars [the total of all increases in Medicare spending over 10 years] is a giant first step. Let's begin."

He added that in response to a February letter from Reps. William Thomas (R-Calif.) and Nancy Johnson (R-Conn.), HHS was developing a list of recommendations about budget items that could be cut to offset proposed increases in physician reimbursement under Medicare.

As of press time, the House had passed a budget resolution that would allocate $350 billion over 10 years for a Medicare drug benefit and a Medicare reform proposal, and the Senate was expected to pass a resolution with a larger Medicare figure.

"The President's Fiscal Year 2003 Budget: An Overview of Health Programs" is posted on the Web at <www.kff.org/content/2002/4041/>. ■

AACAP Parameter

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of the nursing staff, and there should be an R.N. and at least one other nurse on each unit," he said. In addition, the staffing ratio should be flexible enough to allow for one-on-one monitoring of patients when the need arises.

The practice parameter mentions the need for staff training and describes how to involve staff in the prevention and management of aggressive behaviors and seclusion and restraint, as well as when and when not to use the restrictive procedures.

The practice parameter also describes relevant sections of the interim final rule on seclusion and restraint from the Department of Health and Human Services and seclusion and restraint standards from the Joint Commission on Accreditation of Healthcare Organizations.

AACAP members may download "Prevention and Management of Aggressive Behavior With Special Reference to Seclusion and Restraint" at no charge by going to the "Members Only" section of the AACAP Web site at <www.aacap.org>. Nonmembers have to pay $15; more information is available online at <www.aacap.org/publications/pubcat/guideline.htm> or by phone at (202) 966-7300. Masters can be reached by e-mail at KMASTER105@earthlink.net. ■

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Preemies

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(2 percent) than among controls (1 percent). In addition, Hack said there is evidence in the medical literature to suggest that the presentation of attention-deficit/hyperactivity disorder may differ among preemies—an hypothesis that subsequent research will also explore. She said it is possible that preemies who develop ADHD have a more marked presentation of attention problems but less hyperactivity.

For now, she highlighted the study's positive findings. "Overall the children are functioning fairly well," she said. "It is true that there is lower IQ and less educational achievement, especially among males, but the subjects are functioning."

Hack noted that the study also looked at rates of employment and found them to be similar among both preemies and controls.

One of the more intriguing hypotheses to emerge from the study is the idea that the relatively good outcome of preemies overall—and particularly their lower rates of risk-taking behavior—may be due to family resilience and increased paternal monitoring of children.

The idea was addressed in an editorial accompanying the study by Marie McCormick, M.D., Sc.D., of the Harvard School of Public Health.

"Clues to the nature of this resilience may be found in studies demonstrating that although very-low-birth-weight children accurately characterize themselves as having more health-related and learning difficulties than their normal-birth-weight peers, their ratings of their health-related quality of life are higher than those of their peers," McCormick wrote in her editorial.

Fassler agreed that the hypothesis is worthy of more research, but said it remains speculative. "Another hypothesis is that these are kids who have more contact with the health care system," he said. ■

Prevalence Rates

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the lower estimate. If only one survey addressed a particular disorder, then they used the results from that survey. For instance, their revised prevalence rates for generalized anxiety disorder and posttraumatic stress disorder were based on the NCS data. Their revised prevalence rates for obsessive-compulsive disorder, antisocial personality disorder, and anorexia nervosa were based on the ECA data.

By using this methodology, Narrow and his team reported, the discrepancies between the results of the two surveys declined, and the prevalence rates for mental disorders were generally lower than what they had been before.

The lower rates (see chart on page 2), they believe, more realistically reflect the true incidences of mental disorders in the United States than had the older rates. "These revised rates represented a group of persons with higher levels of disability and suicidal ideation than in previous estimates, which we consider preliminary evidence of the validity of the data," they pointed out in their report.

The good news about these new figures, Narrow and his fellow epidemiologists wrote, is that they are more likely to represent people in need of mental health services than the old figures showed. The bad news, however, is that "even when disorders are restricted to those with clinical significance, their numbers are still overwhelming for planning purposes."

Also, they commented, "very little is known about the clinical significance and treatment needs for disorders that are not currently included in epidemiologic surveys, such as most personality disorders, adjustment disorders, and impulse control disorders."

In an accompanying editorial, Jerome Wakefield, Ph.D., at the Institute for Health, Health Care Policy, and Aging Research, and Robert Spitzer, M.D., a psychiatrist at Columbia University who led the development of *DSM-III* and *DSM-III-R*, agreed with Narrow and his team that the two surveys had some serious problems. But they questioned whether adding a clinical-significance criterion to analysis of the surveys' data really provided more valid mental disorder prevalence rates than those that had been initially reported. In fact, Wakefield and Spitzer wrote, the new analysis by Narrow and his colleagues addresses not disorder rates but a different entity: treatment need. The authors offered no conceptual argument that the addition of their clinical significance criterion "represents a valid redefinition of disorder."

The research that Narrow and his team undertook to revise the prevalence rates was funded by the American Psychiatric Foundation and by the van Ameringen Foundation.

An abstract of the report, "Revised Prevalence Estimates of Mental Disorders in the United States," is posted on the Web at <http://archpsyc.ama-assn.org/issues/v59n2/rfull/yoa20120.html>. ■

residents' forum

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ECT as a great treatment. In his view educators should increase attention to the body, medical comorbidity, pharmacokinetics, dynamics, and drug-drug interactions until every candidate for the board understands the implication of the fact that the brilliant musician George Gershwin died of an intracranial tumor after being put on the couch for two years.

In answer to a question about genetics, Dr. Strain noted that the topic reminds us that while we cannot know everything, we need to figure out what are the minimums for a psychiatric education. Some genetic disorders can be very complicated. Psychiatrists should know about them and how to navigate them much like one learns Mendeleyev's system rather than the facts of each atom individually. The same goes for drug-drug or p450 interactions. Training directors, he argued, need to teach us what to know and how to access it, but not to remember it all. To this, Dr. Yudofsky noted, "I can agree with that."

What aspects of the mind, brain, and body should be taught to psychiatry residents? It is clear from this workshop that the answers hinge, to a great degree, on how one views the current state of the profession and where he or she would like it to go. These four experts offer different assessments; it is hoped that we can all think together on where to go from here. ■