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Association

PSYCHIATRIC NEWS

Special Annual Meeting Exhibits Guide — See Pages 39 to 41

"see" references appear on pages 1, 13, 24, 58

At last month's Board of Trustees meeting, Trustee-at-Large Patrice Harris, M.D., discusses strategies she and her colleagues in Georgia successfully used to dissuade state legislators from enacting a bill to grant prescribing privileges to psychologists. Listening to Harris are Area 6 Trustee Maurice Rappaport, M.D. (far left), and Area 2 Trustee Herbert Peyser, M.D. More information on the Board meeting appears on pages 8 to 11.

Government News

Bush Angers Patient Advocates With Plan to Ease Privacy Rule

APA and other patient-privacy advocates denounce a proposal to roll back a patient-consent requirement in the federal rule governing confidentiality of medical records.

BY CHRISTINE LEHMANN

The U.S. Department of Health and Human Services (HHS) proposed several revisions to the medical privacy rule last month, the most far-reaching of which would eliminate the patient-consent requirement for use or disclosure of medical-record information. Specifically, the change would delete the requirement that physicians, HMOs, and other treatment entities obtain written consent from their patients before using or disclosing medical information for treatment, payment, or other health care functions.

HHS Secretary Tommy Thompson said the reversal on the patient-consent mandate last month was justified because the requirement would have "created serious unintended consequences that would interfere with patients' access to health care."

The requirement was so burdensome, he suggested, that patients could have been required to visit a pharmacy in person to sign paperwork before a pharmacist could fill out a prescription. "Doctors could refuse to treat patients who refused to sign their privacy consent form," said Thompson.

Instead, under the revised rule HHS proposed in March, physicians and other clinicians would have to notify patients about their privacy rights and make "a good-faith effort" to have patients acknowledge that notification in writing. "But, doctors could treat them even if they did not" provide such an acknowledgement, said Thompson.

The proposed change is strongly opposed by APA, which has long held that patient consent is necessary before medical information is released.

President-elect Paul Appelbaum, M.D., said, "APA has long seen confidentiality as the foundation of the therapeutic alliance between patients and their psychiatric physicians. Patients, and not the government, should control the release of their medical information. Whether by written or oral means, patient consent should always be required prior to disclosure of medical information."

Sen. Edward Kennedy (D-Mass.), chair of the Health, Education, Labor, and Pensions Committee, said that this proposed change would "wipe away the most important protections an individual had—their ability to say no to sharing their medical

see ***Privacy Rule*** *on page 62*

Yates Case Puts Mental Illness In Media Spotlight

Efforts to educate the media about mental illness in the past decade appear to be paying off, as evidenced by responsible media reports on such disorders as postpartum depression and schizophrenia during the Yates trial.

BY MARK MORAN

Not since the trial of John Hinckley has there been as sensational a court case involving a defendant pleading not guilty by reason of insanity.

But in contrast to the Hinckley trial, APA leaders say media coverage of the trial of Andrea Yates—convicted last month for the murder of her five children by drowning—was notable for its balanced and sympathetic portrait of severe mental illness. Even those who were dismayed at the verdict—and the strict legal definition of insanity that Yates was required by Texas law to meet (see page 22)—say the case proved an opportunity for public education.

"I was impressed with the media coverage of the case and the extent to which it was an opportunity to educate the public about postpartum depression and psychosis and the relationship between mental disorder and violent behavior," said APA President-elect Paul Appelbaum, M.D. "I think the impact in terms of educating the public was positive."

Jeffrey Metzner, M.D., chair of APA's Council on Psychiatry and the Law, agreed.

"Unlike the Hinckley case, where the public perception was that he knew exactly what he was doing and got away with a sig-

see ***Media Coverage*** *on page 61*

Legal N

Child Mental Health Care: Knowledge Versus Reality

The gap between what we know and what we do about mental health services for children is widening, according to authorities in the field.

BY KATE MULLIGAN

It's the best of times and the worst of times for children who need mental health services, according to speakers at a recent press briefing in Washington, D.C.

In March, the National Mental Health Association (NMHA) and five other organizations, including the American Academy of Child and Adolescent Psychiatry (AACAP), sponsored the briefing, "Falling Through the Cracks: Children and Our Nation's Mental Health System."

Former APA President Mary Jane England, M.D., president of Regis College in Massachusetts, told the audience, "The good news is that we know what works and what doesn't work."

Mary Jane England, M.D.: "We tried so hard to get kids with mental health problems mainstreamed."

Multisystemic therapy (MST), a treatment approach that addresses both the individual child and the child's context, for example, is a promising intervention, she said—that is, treatment of an entire family, rather than the child as an isolated individual, promotes treatment success.

Cognitive-behavioral therapy has been shown to be an effective method of treatment for PTSD and various panic disorders, England said. She also noted that research that looks at factors promoting resiliency offers hope for identifying ways to promote psychological strengths.

In contrast, services for delinquent juveniles, such as boot camps and residential programs, have proven ineffective, as have peer-based interventions, she stated.

England chaired a National Institute of Mental Health work group on child and adolescent mental health intervention development and deployment that produced "Blueprint for Change: Research on Child and Adolescent Mental Health" in 2001.

New and Old Problems

Psychiatrists, mental health professionals, and advocates have not, however, been able to translate these research findings into widely available services.

In fact, Rep. Jim McDermott, M.D. (D-Wash.), who began to practice child psychiatry more than 30 years ago, said, "There's never been a time when it has been more difficult for kids with mental illness to get treatment."

England described a series of recurrent or newly surfacing problems.

"We tried so hard to get kids with mental health problems mainstreamed," she said. Now, programs of zero tolerance for substance abuse can result in excluding them once again and can also promote their entry into the juvenile justice system.

In addition, turf battles at the Substance Abuse and Mental Health Services Administration (SAMHSA), according to England, have inhibited the growth of services that recognize the comorbidity of mental health and substance abuse problems.

The effectiveness of Medicaid mental health services and the Children's Health Insurance Program (CHIP) are seriously threatened by state budget constraints, according to NMHA President and CEO Michael Faenza (*Psychiatric News*, January 4; February 1).

An increasing number of states are cutting back on CHIP, according to reports from kaisernetwork.org. States considering cutbacks or caps on enrollment include Washington, Kansas, Iowa, Utah, Montana, New Mexico, Missouri, and Idaho.

"The New Medicaid and CHIP Waiver Initiatives," a report from the Kaiser Commission on Medicaid and the Uninsured issued in February, describes the Health Insurance Flexibility and Accountability (HIFA) initiative in which states are offered the flexibility to expand coverage, but also to reduce benefits, increase cost sharing, and set limits on the number of low-income people served.

The winter 2001 issue of *NMHA State Advocacy Update* offers additional information about the impact HIFA could have on children and others with mental illness.

Many of the Medicaid benefits that people with mental disorders or substance abuse problems use could be cut, including prescription drugs, rehabilitation services, practitioner services (including therapy for a range of services), clinic services, case-management services, inpatient psychiatric services for those under age 21, institutions for mental disease services for those over 64,

see ***Children*** *on page 62*

from the president

Psychiatry in the News

BY RICHARD HARDING, M.D.

I have come to appreciate the fact that APA members are most willing to register their thoughts and suggestions on psychiatric issues to their elected leadership. In complex times, like these we live in, this communication has allowed both an early warning and a diversity of opinion that has advanced the causes of our patients and our profession.

This issue of *Psychiatric News* is packed with items that will increasingly affect each of us. I cannot remember a time when psychiatric issues were so prominent in the national media and the political and regulatory process. I cannot remember a time when so many members of APA were involved in helping to create and to guide these media stories and shepherd legislation and regulations on state and federal levels. Our members who have developed their skills in working up front and/or behind the scenes add value to these programs and articles and continue to show their professionalism by making sure that the best interest of the patient is at the forefront of each.

A vexing problem for me as president is being called by a reporter from a prominent newspaper or national newsmagazine and being asked, "What is APA's position on this issue?" In most cases, I must respond that APA has no official policy, and I can only give them my own opinion as one individual psychiatrist. APA's position statements require approval by the Assembly and the Board of Trustees. In a group of 36,000 psychiatrists, there are many opinions strongly held. For instance, we have no official policy on the death penalty in general, but we do have a policy against the death penalty for capital offenses committed by a minor. As we go forward, we will need to develop official policies based on scientific evidence, clinical experience, and the ethics of our profession. It will take an open mind, professional skills, and hard work to develop these policies. Perfection is the enemy of good.

The debate around confidentiality of medical records continues to heat up. All psychiatrists understand that privacy and confidentiality in the doctor-patient relationship and confidentiality of medical records are essential to good patient care. Many of our medical colleagues are concerned with the burden of assuring that confidentiality is placed on physicians and

see ***From the President*** *on page 60*

Business Prepares Workers To Direct Own Health Care

Business leaders are attempting to transform employees into active, educated consumers who will have more of a say in their health care choices and pay their share of rising health care costs.

BY KATE MULLIGAN

Talk has turned to action when it comes to moving from managed care to a consumer-driven health benefits system.

In March panelists at Business Health Agenda 2002, an annual meeting sponsored by the Washington Business Group on Health (WBGH), outlined steps their companies had taken to transform employees into consumers who are responsible for choosing and paying for benefits and for making educated decisions about how to enhance their own health.

The impetus for the change? At the current rate of increase in health care costs, employers face the prospect of doubled health benefit costs by 2007.

Brian Marcotte, vice president of Benefits and Compensation Programs at Honeywell, said his company's goals are to transfer risk management to employees and to decouple the relationship between compensation, contribution, and health care costs.

He added that with managed care, "we created passive consumers with no skin in the game."

Peter V. Lee, president and CEO of the Pacific Business Group on Health, pointed out that from 1993 to 2001 the employee share of premiums declined by 25 percent.

Robert O'Brien Jr., U.S. practice leader at William M. Mercer Inc., characterized managed care as a "top-down" system that contrasts with a consumer-directed system that operates from the bottom up.

Employers Promote Consumerism

WBGH and Watson Wyatt Worldwide (WWW), a consulting and financial management firm, released findings from a survey conducted in November and December 2001 of 292 employers that collectively provide benefits to more than 10 million employees and dependents.

They found that consumerism is the strategy that respondents are adopting at the fastest rate to combat rising health care costs. Nineteen percent of the respondents had strategies promoting consumerism in place, and 43 percent had such strategies planned for the next year.

Although noting the lack of a common definition, the WBGH-WWW survey says that consumerism generally refers to systems that inform and empower employees to participate more actively in health care buying decisions by putting them in charge of spending their own health care dollars.

Defined contribution plans, for example, are a benefits offering in which the employer contributes a specified amount toward benefits and shifts the risk and responsibility for the use of that money to the employee. The basic approach comes from the defined-contributions model for pensions in which the employer no longer guarantees a specific annual payout upon retirement (*Psychiatric News*, December 21, 2001).

A WWW survey of 200 companies, 68 percent of which have at least 1,000 employees, found that 20 percent of their respondents thought it likely that they would offer a defined contribution option during the next 12 months. The survey was titled "Health Care Costs 2002."

Consumer Empowerment

What will it take to realize a vision of empowered consumers making wise decisions about benefits and their own health? Access to information and education, according to employers.

Of the employers responding to the WWW-2002 survey, 75 percent reported that they were likely or somewhat likely to support employee health education with Web-based materials in the coming year.

Honeywell and several other large employers have undertaken an even more ambitious educational effort.

In 1999 Honeywell contracted with Consumer's Medical Resource (CMR) to provide expert information to members of its health plans who suffer from serious (and therefore, costly) medical conditions.

Marcotte noted that approximately 10 percent of the population is responsible for 70 percent of health care costs.

CMR contracts with physicians from prestigious medical schools and puts staff to work analyzing medical publications to come up with the most current information about treatment options for conditions like cancer, Parkinson's disease, and organ failure.

CMR founder David Hines told *Psychiatric News* that the company offers "an informed-decision-making service," not merely a second opinion. The aim is to give a patient all the information necessary to make a good decision about treatment.

Marcotte told the audience about one plan member who had been treated for Parkinson's disease for over a year and had moved to a new home with a wheelchair ramp. After he asked his doctor questions suggested by CMR, the patient discovered that he had never had an adequate diag-

see ***Business*** *on page 65*

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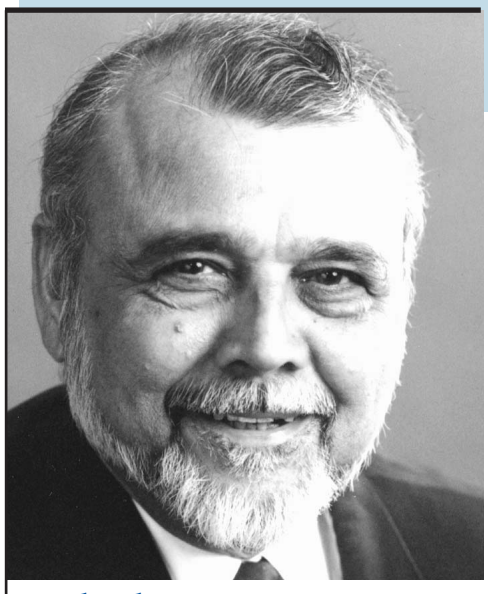
create section called “Assembly Election”

THE APA ASSEMBLY will elect a speaker-elect and a recorder at its May meeting in Philadelphia. The candidates for these positions were asked to provide *Psychiatric News* with biographical and candidacy statements. These statements are published here to keep APA members informed of the candidates' views and encourage APA members to contact their Assembly representatives about the election.

Assembly's 2

CANDIDATES FOR SPEAKER-ELECT



Prakash N. Desai, M.D.

Biographical Statement

Biographically speaking, not much has changed in my life this past year, except for my year as your recorder.

In my first responsibility I have communicated to all of you, in a timely manner, the proceedings of the Assembly and those of the Joint Reference Committee. As a first-time member of the JRC, I have strongly advocated on behalf of the Assembly. The first occasion for that was the issue of amendments to the APA Bylaws. The Assembly's action asking that the amendments passed by the Board be ratified by the Assembly had to be argued forcefully. As you know, it went on the ballot to general members, failed on account of insufficient numbers voting, but otherwise received over 90 percent support. At its last meeting, the Board approved the Assembly's request for a role in making amendments to the bylaws.

I also attended the Area Council meetings of all the APA Areas last fall. I came away not only with a better appreciation for the diversity of the Areas and the workings of the councils, but also for the breadth and depth of the discussion of issues. I have served on APA's Commission on Public Policy, Litigation, and Advocacy and gained a better understanding of what legislative battles we must fight at the state level.

I continue in my position as chief of staff at the West Side Division of VA Chicago Health Care System and as professor of psychiatry and associate dean at the College of Medicine of the University of Illinois at Chicago.

I have applied my knowledge and understanding of the organized health care delivery systems and of the sociocultural issues to my work in the Assembly. I hope I have earned your support and deserve your vote as speaker-elect of the Assembly.

I will be honored to continue to serve you.

Candidacy Statement

A year ago, when I wrote in these pages asking for your support as recorder, little did I know what the coming year had in store for us. The events of 9/11 continue to reshape the world, our thinking, our safety and security concerns, and the well-being of millions around the globe. PTSD has become a household word, and psychiatry has received renewed public attention.

At APA the impact of 9/11 accentuated the problems of our fiscal integrity. Now we are in the middle of a major internal reorganization, forced on us to a great extent by pressures generated by a weakened economy. Independent of these catastrophic and tragic events, we have other problems. Membership losses continue to plague us, and we fail to fully appreciate the dynamic that leads to the loss of investment in the organization by those who choose to leave.

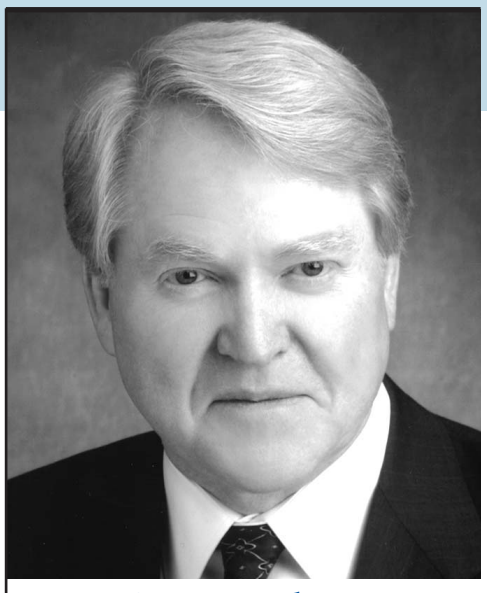
The Assembly is under pressure, as are other segments of APA, to conserve resources, and we must respond. I see the Assembly as having two major functions. The first is to represent all its district branches and the diversity of its membership. In this function, which has expanded over the last 15 years, we have brought within our fold MURs, MITs, ECPs, and, most recently, the allied organizations. I believe this expansion has greatly strengthened the Assembly and made it more representative. The other function is legislative, which has also been expanding. A special feature of the Assembly is the Area Councils, in which issues are first flushed out. I especially value the vitality that the Area Councils bring to our deliberations.

In an effort to conserve resources in the last few years, we have already reduced our expenses by close to a third and yet preserved most of our vital functions. I see that we have two major choices: reduction in the size of the Assembly or reduction in its functions. Given that we must make a choice, I prefer a smaller Assembly, that is, a reduction in size, in a way that maintains representation of each district branch and the other groups, and no reduction in its functions. In fact, I advocate a greater legislative role for the Assembly in the governance of APA. A different numerical formula may allow us to reduce our size. It may also present an opportunity to involve DB presidents-elect in a formal and a structured fashion. In the coming months I promise to work with each of you to help negotiate a resolution that leads to a more vibrant Assembly and, in the process, add efficiency and increase our efficacy.

I cherish the mission of our Association, which is to advocate for our patients and enhance the values of our profession. As I articulated last year, **access to care** is a central issue for patients and psychiatrists alike.

Excesses of managed care must be contained, and **erosion of public funding** for services must be stemmed. **Nonphysician practice of medicine** has highlighted problems of **access in rural areas.** We must renew our resolve to redress the difficulties and strengthen our **legislative efforts at the state level.** The **bleeding of our membership** must be stopped. We must search hard and look within to better respond to the needs of our members. While we exercise **fiscal restraints,** we must not lose sight of our objective.

The Assembly, as that part of APA that most truly represents the practicing psychiatrist, is being challenged as never before. I offer my leadership skills as speaker-elect to meet the challenge so that together we can create a more effective and more responsive APA. ■



Louis A. Moench, M.D.

Biographical Statement

Fascinated by my psychiatrist father's wall of books and his late-night dinner conversations with my artist mother about the encounters of the day's practice, it was determined in the genes and the kitchen that I become a psychiatrist. Medical-schooled at the University of Utah, my professional path was diverted five years by church service in Germany, a public health project in Greece, moonlighting as an obstetrical extern, and defending or offending us, depending on perspective, from the back seat of an F-105 as a flight surgeon during the Vietnam War.

The beauty of my career choice is that it allows me to be a philosopher, biographer, theologian, and teacher and still doctor patients. My mentors at the University of Pennsylvania exemplified the above, among them Stunkard, Beck, Luborsky, Brady, Minuchin, and Sadoff.

I have been practicing adult inpatient and outpatient psychiatry for 25 years in a large, private multispecialty group recently bought by Intermountain Health Care, a not-for-profit organization now recognized as the best vertically integrated system in the nation. The reputation is close to deserved.

My patients receive pharmacotherapy, psychotherapy, and sometimes electroconvulsive therapy, and my inpatients a hospital visit from me seven days a week. My workweeks are extended by forensic practice, “professing” on the clinical faculty of the University of Utah, and occasional examining for the ABPN. Professional society and community service includes testifying on matters mental before the state legislature and lecturing often to professional and civic groups, including the newspaper readership and the audience of the 10 o'clock news.

My life is enriched by my violin-teacher wife and three musician children, who form a beautiful string quartet, and an oldest son soon to head west from the University of Virginia School of Medicine with wife and baby to begin a psychiatry residency, extending the Moench psychiatry legacy three generations, maybe four.

Candidacy Statement

Ten years ago, after serving with considerable activism as president of my district branch and representative to the Assembly, I was asked by the Nominating Committee to be a candidate for speaker. I wisely turned them down. My name turned up again this year, and I consented—a more informed consent after 10 additional years of experience—because I see an opportunity to give back to my profession some measure of recompense for what APA gives my patients and me.

I have counseled with the Area 7 Council eight years as Area representative and deputy, executed with the Assembly Executive Committee, planned with the Committee on Planning, and proceeded with the Committee on Procedures, for six years as chair, to make innovations in the Assembly and hence the Procedural Code.

Beyond governance, my work has been mainly with components producing work products—the Committee on Psychiatric Diagnosis and Assessment (produces and revises the *DSM* and keeps us in the forefront of nosology), the Steering Committee on Practice Guidelines (11 so far and available this May in one bound volume), the Committee on Electroconvulsive Therapy (generated the definitive volume of ECT practice recommendations and now oversees TMS and VNS), and the Practice Research Network (finds and publishes what psychiatrists in the field do, not just what is done in ivory towers).

Such products benefit not only psychiatry but all mental health disciplines, and not just in the United States and Canada but worldwide.

I favor strengthening and funding those components that create products. These are a few of the myriad ways in which APA has bettered our practice and the mental health of millions. We have been and must remain the bearers of the world standard.

Nevertheless, we are facing crises from without. We and our patients have never been embattled more by economic discrimination; by unreasonable limits to access, type, and extent of care; by challenges to privacy in electronic record keeping; and by expansion of scope of practice by legislative fiat rather than training. Many psychiatrists don't realize that conditions would be more ominous in each of these areas had we not had a vigorous APA intervening. (We would, for example, have psychologists' prescriptive practice in half a dozen states, not just New Mexico.)

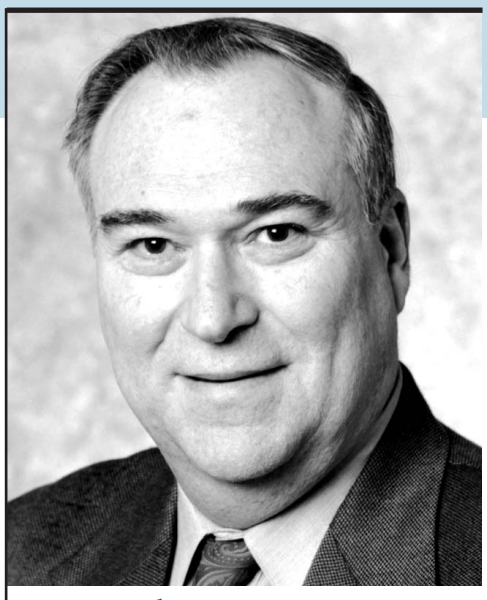
And we are facing crises from within. We lack ability to intervene decisively, rapidly, and effectively as an organization due in part to the disappearing of members and revenue. Too much decision making has shifted from peripheral to central when the fires burn in the states.

We have all but pulled the plug on our state legislative structure. A major reorganization is called for, one that will carefully sift the many activities we could be and have been involved in to assure maximum value for effort and dollar and inspire those psychiatrists not with us to get on board.

How to do this? I don't know! It is not the job of the speaker to know. But all of us together know. I have ideas. You all have ideas. Some are even good ones. It is the job of the speaker to foster your ideas, to enable your expressing them, to make all of you speakers, and when you have spoken, to recognize the best answers and synthesize them into actions. When the Assembly has decided, the speaker speaks vigorously to the Joint Reference Committee, president, Board of Trustees, medical director, and whoever must hear the will of psychiatrists everywhere through their elective representatives. I can speak for you, and if you support me with your vote, I will. ■

002 Election

CANDIDATES FOR RECORDER



Larry Kline, M.D.

Biographical Statement

This is my record of leadership.

I first became active in the Suburban Maryland Chapter of the Washington Psychiatric Society in 1975, leading an effort that improved the state Medicaid payment for office psychiatric treatment 500 percent. Next, I led the effort that nearly doubled the payment required by our state's parity law. Graduating to the district-branch level, I led the battle to enact a parity law in D.C., one that remains the best in the nation, far superior to the bill that recently passed the Senate. While president of the WPS in 1985, the first for-profit mental health carveout company was started. I had our attorney warn the company not to defeat the purpose of parity and was threatened with a lawsuit. I then wrote the very first action paper on managed care in the Assembly while still a DB president.

During my 16 years in the Assembly, I have served as an Area representative and as chairman of the ad hoc Assembly Committee on Managed Care. Working with Larry Sack, we formed the Private Practice Caucus. We gained passage of an action paper calling for the establishment of the Committee on Psychotherapy. I was one of the initial members appointed to that component. I served as chair of the Council on Economic Affairs, helped Steve Mirin to form the Council on Quality Improvement, and have served on that council and on its Committee on Quality Indicators. As APA's representative to the URAC Standards Committee, I was the first physician elected its chair.

At Suburban Hospital in Bethesda, I serve as medical director for psychiatry. Our hospital achieved the highest JCAHO rating in the area. Having become boarded in geriatric psychiatry, I helped found and have served as medical director of our county's only geropsychiatric program that recently achieved a three-year CARF certification.

Candidacy Statement

Reestablishing the Relevance of the Assembly

Many in the Assembly perceive it as a group that is under attack and losing its relevance to APA. If elected, I will lead a renaissance of our role in governance. I will focus on our leadership in retaining current members and recruiting new ones, in reversing the defunding of our treatment services, and in protecting the quality of the services delivered to the public.

Retaining Loyalty Through Fairness in Appointments

The Assembly is the incubator of leaders for the Association. A review of the statistics demonstrates that our major challenge in the striking reduction in our membership lies with recruitment and retention of early career psychiatrists and from competition with subspecialty associations. If an influential, active psychiatrist becomes frustrated because he or she finds himself or herself unable to make his or her views heard, because he or she is unwilling to wait 20 years for a major appointment, that psychiatrist is going to find a more receptive home in a subspecialty group and take his or her friends along. What ought to count in the appointments process should not be who you know or how long you've known them, but what you know. If I am elected, I will follow this principle.

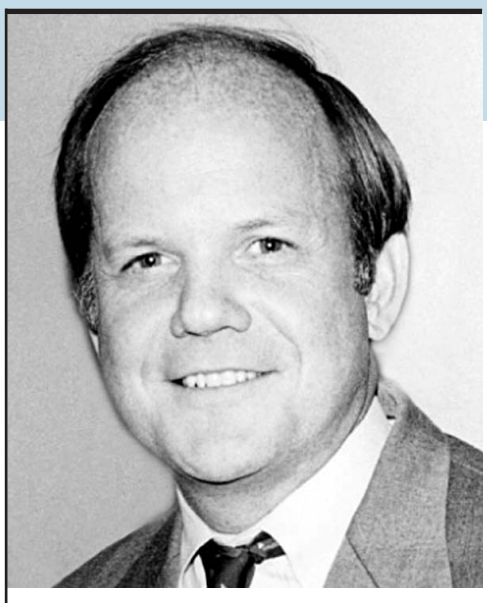
Getting Our Hand Back on the Financial Tiller

As medical director of our local hospital's Behavioral Health Service, I successfully negotiated a two-thirds reduction in the frequency of reviews required for the approval of partial hospital treatment and a nearly three times increase in the number of days initially approved for substance use rehabilitation. Our administrative director and I took advantage of a situation in which a major managed care company was being threatened with the loss of a major contract. We created the leverage that made our negotiation a success. We must deal with these folk with toughness, savvy, and persistence. My election will strengthen the Assembly's leadership team and improve the Assembly's influence on private sector issues. But I also understand the vital importance of the public sector and work on APA's Work Group on Financing the Treatment of Chronic Mental Illness to improve funding. And I am not so foolish as to think that, ultimately, this nation's system of employer-owned health care insurance should survive. That's why I am working to develop a medical savings account proposal that will be acceptable to both political parties; assist low-income, retired, and disabled people; as well as help provide for the financial security of contributors. The earnings from the investment of health care insurance dollars belong to those who pay for the insurance!

Guardians of Quality

Those of us in the Assembly are closest to the grass roots. In our nation, licensing professionals and defining their scope of practice are duties of our states and vary from state to state. It is our responsibility to make this our most important quality-of-care issue on the DB level. We must tell our legislators and our medical colleagues that the medications we use can be just as dangerous, even lethal, as any others used in medicine. We must lead our DBs toward an even more active involvement with state medical associations. Any professional seeking to prescribe medications should demonstrate competence in the basic medical sciences, as we already do. We must point out that psychologists with prescribing privileges are no more likely to leave Santa Fe and Albuquerque and move to Truth or Consequences, N.M., and to their counterparts in other states than were psychologists without them.

It's time for Kline. ■



James E. Nininger, M.D.

Biographical Statement

During my residency at Mt. Sinai Hospital in New York, I found an interest in psychodynamics grow to include psychiatric teaching and neurobiology. As a chief resident, I received an award for medical student teaching, and several years later served as director of the third-year medical student clerkship, and then as assistant director of residency training, at Cornell, the Payne Whitney Clinic. Also at Cornell, during two years as a unit chief, I developed an interest in geriatric psychiatry, which today is my main subspecialty interest. I am in private practice in Manhattan and work two days a week with adolescents at a residence for inner-city children in Westchester County.

I am a clinical associate professor of psychiatry at Cornell and volunteer time at Payne Whitney in supervision, teaching, and interviewing resident applicants. I have published individually and collaboratively in the areas of geriatrics, psychiatric education, and psychopharmacology.

I am the Area 2 representative to the Assembly and am concluding my second term as president of the New York State Psychiatric Association, having previously served as treasurer and vice president. I entered the Assembly as one of the representatives from the New York County District Branch in 1988. I have served the Assembly as liaison to the Committee on Family Violence and Sexual Abuse and the Commission on AIDS, and have been the representative from Area 2 to the Steering Committee on Practice Guidelines and the Practice Research Network since their inception. I have chaired the Assembly Committee on Planning for the past three years.

At the New York County District Branch, I established the first Task Force on Psychiatry and Nursing Homes and have chaired the Committee on Aging since 1989. I was among the first group of psychiatrists to volunteer services to the homeless and this fall worked at Pier 94 and ground zero with Disaster Psychiatry Outreach.

Candidacy Statement

Our profession is faced with critical challenges. We must ensure that our patients have improved **access to quality care** and better educate the public, government officials, and our nonpsychiatric colleagues as to the nature, prevalence, and cost-effectiveness of appropriate treatment of mental illness. Stigma, managed care restrictions, underfunding of services, and increasingly liberal scopes of practice allowing nonphysicians to diagnose and treat mental illness (including the prescription of medications!) all contribute to erosion of proper treatment for our patients.

The **Assembly** has tremendous potential and opportunity to organize our members and coordinate activities between members, the Board, and medical director. **Membership** strength and involvement are crucial and have been on a steady decline. At the same time we expand and refine our electronic communication abilities, there needs to be greater personal outreach by Assembly reps to members in the field, and we need to impart to training directors and early career psychiatrists the importance of psychiatrists' active involvement on behalf of our patients. This includes strengthening liaisons with state medical societies and advocacy groups. In New York a strong alliance with the medical society has helped us to avoid intrusions into our scope of practice. In New Mexico a lack of significant input and representation from psychiatrists in the medical society seems to have been part of the reason for the passage of the psychology prescribing bill. To foster recruitment, we must continue to forge alliances with our allied psychiatric groups, consider shared dues strategies, and be sensitive to the needs of international medical graduates and minority representatives, many of whom serve valiantly in the public sector.

It is time for true **fiscal responsibility.** The Assembly played an important role this past year in stressing the need for prioritization of goals, removal of redundancy in committee and component functions, and the establishment of financial oversight mechanisms so our right hand knows what our left hand is doing. Assembly budget cuts ($265,000 from fiscal years 2000-01 and an additional $97,000 mandated for 2002) have reduced our funds by approximately one-third. The degree of these cuts risks fragmentation of communication with legislative and public affairs reps, executive directors, and presidents and presidents-elect of our district branches, the very people we previously identified as needing to be in close touch with the Assembly and with one another! Governance (the combined budgets of the Assembly and Board) represents not more than 4 percent to 5 percent of the total APA budget. In striving to improve efficiency, the Assembly must be careful to not needlessly further diminish its ranks and capabilities. I have suggested we consider having Assembly Area reps serve as Area trustees, which would be cost saving and help ensure Assembly/membership issues are well represented on the Board. This would obviate the need for further discussion of how to get the Area reps and Area trustees communicating regularly.

I am in favor of continuing our Area Councils and support steps to strengthen regional alliances with stronger central office support and availability. Difficulties in establishing a viable **Information System** have damaged morale in DBs through lack of an adequate available database and timely reporting of dues billings. A separate IS work group within the Board has recently suggested concrete steps to rectify this. Similarly, I support the establishment of an expert business and financial advisory panel to serve as consultant to the Board in its consideration of various initiatives (i.e., Medem). Assembly vigilance, including Assembly involvement on the Board, will make sure these issues are tracked through Dr. Appelbaum's Long- Range Budget and Planning Task Force.

The Assembly must represent the heart and conscience of APA. I feel one of my strengths is in getting along and working well with diverse groups to establish a reasonable consensus and would be honored to serve as your recorder. ■

Board Votes to Revamp Components, Move APA Headquarters

APA Trustees vote to reform and streamline the component structure and to reaffirm a controversial decision to move APA's national office to Arlington, Va., about two miles from its current location.

BY KEN HAUSMAN

A vote by the APA Board of Trustees at its March meeting will result in a more efficient and less costly structure for the dozens of councils, commissions, committees, and task forces that help APA set its agenda and achieve its goals.

A task force appointed in January worked quickly to devise a new component structure that better aligns committees and councils to meet APA's strategic goals. (The goals are advocating for patients; advocating for the profession; supporting education, training, and career development; defining and supporting professional values; and enhancing the scientific base of psychiatric care.) The process was also budget-driven, noted APA Vice President Marcia Goin, M.D., who cochaired the restructuring task force along with Jon Gudeman, M.D.

The structure the Trustees approved at last month's meeting reduces the number of components from 106 to 88, and the number of positions available on these components from 654 (plus 232 corresponding members and consultants) to 532 (plus 124 corresponding members and consultants). The task force estimates that these reforms will reduce the cost of the component structure by about $700,000, or 50 percent, Goin pointed out. Most of that cost goes to pay travel and meeting expenses for the fall component meetings held every September at a Washington, D.C., hotel.

Three "generations" of chairs of APA's Budget Committee attended the Board's March meeting. From left are Steven Sharfstein, M.D., who chaired the committee from 1986 to 1990; Donald Scherl, M.D., who became chair in 1990 and will step down in May; and Jack Bonner, M.D., who becomes chair in May.

The components also meet in conjunction with the APA annual meeting.

Residents who are assigned to committees and other components because they are in fellowships sponsored by pharmaceutical companies will continue to participate as they have in the past, with their fellowships paying for their expenses.

As part of the process for developing their restructuring proposal, task force members talked with the chairs of all of the councils and major components, as well as with the staff liaisons who help these groups carry out their work.

The new component lineup will take effect in May at the close of the annual meeting, and APA President-elect Paul Appelbaum, M.D., said that he will make his component appointments based on the new structure.

The Board acknowledged before taking a vote that the structure was still "a work in progress" that will involve additional tinkering and adjusting.

The proposal the Board adopted has 13 councils overseeing committees, corresponding committees, and task forces. As part of the effort to streamline the structure, there will no longer be commissions and joint commissions; they will all become committees under one of the councils. Several current committees will be converted to corresponding committees, which means they will not have yearly face-to-face meetings at APA's expense, but will be given a budget for conference calls and mailings. Every three years the council to which a corresponding committee reports will reassess the need to continue its corresponding committees.

Several current committees and task forces will be sunsetted. The Board voted, however, to adopt an amendment introduced by Area 3 Trustee Roger Peele, M.D., that requires the component restructuring task force to consult with the chairs of councils before a committee under that council's jurisdiction can be sunsetted. If the council chair disagrees with the suggested termination, that committee will remain in existence as a corresponding committee under the most appropriate new council.

In other actions the Board of Trustees voted to

- **relocate APA's national headquarters** from downtown Washington, D.C., to a building directly across the Potomac River in the Rosslyn section of Arlington, Va. The new site is about two miles from the current headquarters. The Trustees had approved the move last October, but reversed that decision earlier this year, deciding instead to fit the staff into just over half the current space it now occupies. Several Trustees had second thoughts, however, once they had more data about cost, working conditions, and lack of future flexibility of the space. A new vote was held last month, and the Board voted

12 to 6 to relocate. APA will occupy about 60 percent of its current square footage. Over the 15 years of the lease, the move is expected to save APA approximately $700,000 annually, or $10.5 million, compared with renting the reduced amount of space in the headquarters at 1400 K Street, said Chief Financial Officer Therese Swetnam.

• **appropriate $26,000 from the Board's Contingency Fund to support the search process for a new APA medical director.** Search Committee Chair Herbert Pardes, M.D., reported to the Board that his committee has set May 1 as the deadline for receipt of curricula vitae and hopes to be able to bring to the June meeting of the Board the names of the three or four finalists the committee identifies to replace Steven Mirin, M.D., who will be stepping down at the end of 2002.

• **make optional the racial/ethnic identification form** that anyone proposing an annual meeting presentation must submit to the Scientific Program Committee. Instituted as a means of helping to ensure that a diverse group of presenters participates in the program, the form has been mandatory since implemented in 1999.

• **empower district branches to implement a dues amnesty for former members,** with APA then allowing amnesty only for lapsed members within district branches that have instituted an amnesty program. Reinstated members will have to pay dues in advance for the year in which they are being reinstated.

• **enact the amendment to APA's Bylaws that was on the 2002 election ballot** but failed to pass because not enough voting members cast ballots in the election. For an amendment to pass, 33 1/3 percent of APA's eligible voting members must participate in the election. Only 31 percent did so in the 2002 election. Of those who voted, however, 92 percent voted in favor of the amendment.

The amendment requires Assembly approval before a Bylaws change approved by the Board of Trustees can be enacted. A two-thirds vote by strength of the Assembly is required for a Board-backed amendment to be added to the Bylaws. If an amendment vote cannot wait until the next Assembly meeting (the Assembly meets twice a year), the Assembly Executive Committee can vote on the amendment, and if it receives a favorable vote, it will still be subject to a vote by the full Assembly at its next meeting.

With overwhelming backing by the 31 percent of members who chose to vote on the amendment, a majority of the Trustees agreed that they were carrying out the members' wishes, even though the overall vote total failed to meet the required threshold for enactment.

• **approve a new newsletter focusing on the intersection of business and mental health.** The newsletter will be funded by Cyberonics Inc., maker of a vagus-nerve-stimulation device, with APA having complete editorial control and with advertising content subject to APA's "Principles and Guidelines of Advertising Acceptance."

The goal of the newsletter is "to provide credible, timely, and useful information to those in the business community who make the purchasing decisions regarding mental health services." Most of these decision makers have inadequate information on the value of providing employees greater access to mental health

see ***Board*** *on page 10*

MAINE DB PRESIDENT-ELECT PREPARES FOR TOUGH TIMES

William Matuzas, M.D., told the Board of Trustees at its March meeting that he was surprised to be voted president-elect of the Maine Psychiatric Association (MPA) just a few months after he had moved to Maine.

William Matuzas, M.D.

He said his selection after so little time in the state, and knowing only two Maine psychiatrists, was a discouraging symbol of how "amazingly disengaged" district branch members are from the business of the Association at both the state and national levels. For example, he noted that only 21 percent of the MPA's small membership participated in any district branch activities in 2001-2002. He said he is troubled by the fact that only 8 percent of MPA members are in their 30s and that the reluctance of younger members to join "will create real problems" as the district branch tries to confront upcoming challenges. High on the list of challenges, he said, are the expected introduction in the state legislature of a bill to expand psychologists' scope of practice and increasing demand for psychiatric services at a time when mental health care budget cuts are making access more difficult for patients.

Matuzas told the Board that he is trying to "more proactively engage" district branch members and thinking about ways to "revitalize the committee structure" to making serving on a committee a more interesting endeavor for Maine psychiatrists.

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care, particularly how such access can reduce absenteeism and boost productivity. It will describe research, treatment advances, and legal decisions involving mental health care.

• **approve a request from the Commission on Public Policy, Litigation, and Advocacy to contribute funds** to the New York State Psychiatric Association to advocate against legislative efforts to expand the scope of practice of mental health professionals; to the Georgia Psychiatric Physicians Association for a grass-roots campaign it waged in an attempt to defeat psychologist-prescribing legislation in New Mexico; and to the California Psychiatric Association to help in its preparation of a legal brief regarding nonphysicians' scope of practice.

• **approve two resource documents offering psychiatrists guidance** on recent regulations involving psychotherapy notes and patient privacy. Development and approval of the documents, "Documentation of Psychotherapy by Psychiatrists" and "Psychotherapy Notes Provision of the HIPAA Privacy Rule," are timed to prepare psychiatrists to comply with the April 2003 implementation of the medical privacy rules in the federal Health Insurance Portability and Accountability Act (HIPAA).

The former document, which was developed by the Commission on Psychotherapy by Psychiatrists, deals, for example, with resolving conflicting principles regarding completeness of medical records and the circumspection that must be exercised in light of the vulnerability of electronic medical records. It also suggests a 12-part format by which psychiatrists can document psychotherapy sessions. The latter resource document, which was developed by the Council on Psychiatry and Law, explains the specifics of the additional privacy protections HIPAA provides for psychotherapy notes, compared with the rest of a person's medical record. It describes what can be included in those protected notes and exceptions to those additional protections. The resource documents will eventually be published on APA's Web site and in other APA publications.

• **back a change in benefits for international members** that will give them free access to the online editions of the *American Journal of Psychiatry* and *Psychiatric Services.* They will also be able to have access to the American Psychiatric Online Library at the same annual rate that other members pay. (Access to *Psychiatric News* is free already.)

• **endorse a public television series on depression** developed by New York station WLIW and an accompanying national awareness campaign on depression. Council on Research Chair John Greden, M.D., said that APA's endorsement "will strengthen the effort to convince PBS to do the series on a national basis."

• **ask the Rural Psychiatrists' Caucus to make recommendations to the Board and Assembly** on how the psychiatrically ill in rural areas can best be served. The caucus is to have these recommendations by the close of the 2002 Institute on Psychiatric Services in October.

• **endorse the AMA's International Conference on Physician Health,** which will be held in October. ■

Residents Invited To Submit Proposals For Poster Sessions

APA's fall Institute on Psychiatric Services is its user-friendly meeting for psychiatry residents. In addition to having an opportunity to participate in poster sessions, residents can take advantage of numerous special sessions and events just for them.

Psychiatry residents will have a valuable opportunity in October to present their research in poster sessions at a national meeting sponsored by APA. The deadline for submissions is June 3.

From October 9 to 13, APA will be hosting its 54th annual Institute on Psychiatric Services in Chicago. The institute will feature poster sessions that will make it easy for residents who are working on research projects to present their findings to a national audience. In the past, roughly 90 percent of all poster submissions were accepted for presentation at the institute.

Residents will be able to attend the institute at a reduced registration fee of $60 by registering before the September 9 advance registration deadline.

In addition to the poster sessions, residents will find many other sessions and events of interest to them, including leadership and career development seminars, a full-day session on the homeless mentally ill, a residents-only "Meet the Experts" luncheon in which residents will be able to meet and network with nationally known faculty experts, a residents-only welcoming reception, clinical consultation sessions on a wide variety of topics in general and public psychiatry, and mentoring opportunities to residents new to the institute provided by the APA/Bristol-Myers Squibb Fellows and APIRE/Janssen Fellows.

The Institute on Psychiatric Services will also feature an exhibit hall where daily prize drawings and receptions will be held, along with industry-supported breakfast, lunch, and dinner symposia.

Residents interested in submitting poster proposals are asked to obtain a submission form by calling the APA Answer Center at (888) 35-PSYCH. The deadline for poster submissions is June 3. More information is available by contacting Jill Gruber, associate director of the Institute on Psychiatric Services, by phone at (202) 682-6214 or by e-mail at jgruber@psych.org. ■

AIDS Commission Makes Impact, Plans New Initiatives

With limited resources but highly motivated members, APA's Commission on AIDS has produced an astounding array of training curricula and other materials on neuropsychiatric aspects of HIV and AIDS.

BY KEN HAUSMAN

Now that AIDS, with its complex interaction of biologic and psychiatric symptoms, is the fourth-leading cause of death worldwide, it is critical that APA maintain a strong commitment to addressing the disease's neuropsychiatric and behavioral manifestations, said Marshall Forstein, M.D., at the March meeting of the APA Board of Trustees.

If organized psychiatry fails to ensure that HIV/AIDS has a prominent place in its agenda, it will sacrifice care of HIV-infected patients to psychologists and neurologists, he emphasized, who often seem more involved in AIDS care than are psychiatrists, he cautioned.

Forstein, chair of the APA Commission on AIDS, stressed that "psychiatrists must be prepared for new challenges" in treating people with HIV infection or full-blown AIDS. One, paradoxically, stems from advances in treating the disease. The longer life span to which many people with AIDS can now look forward thanks to various combinations of antiretroviral drugs will also mean an increased need for psychiatric services, he noted.

In addition, since these antiretrovirals don't penetrate the brain very well, patients whose bodies otherwise respond to the drugs are still likely to suffer from cognitive impairment. And for those with pre-existing severe mental illness or significant substance abuse, the assessment of cognitive capacity is particularly complex, Forstein pointed out.

Psychiatric involvement in the epidemic is also crucial, he added, because "for the medically ill patient on many medications, potential complex drug interactions require a sophisticated psychiatric approach to the HIV-infected patient."

Marshall Forstein, M.D.: A primary goal of the APA Commission on AIDS is "to more effectively compete for funds to support research and education activities vital to the future of psychiatry."

Forstein pointed out that the APA AIDS Education Project, funded through grants from the federal Center for Mental Health Services, continues to train psychiatrists, residents, and medical students to diagnose and treat the neuropsychiatric dimensions of HIV disease through courses and symposia and via the Web. Last year, Forstein said, the AIDS Education Project "helped to train more than 2,700 clinicians at 33 national, regional, and local programs," including training 391 residents at 13 program sites. Members of the Commission on AIDS serve as senior faculty to the AIDS Education Project.

In addition, he pointed out, the members of the commission and the staff of the AIDS Education Project, whom he praised as hard working and dedicated, have developed extensive training and clinical materials on neuropsychiatric aspects of HIV/AIDS. The curriculum they have developed already contains modules on CNS complications, anxiety disorders, mood disorders, treatment of severe and persistently mentally ill people, psychosis, pain disorders, and sleep disorders. In the works are modules on substance abuse and drug-drug interactions.

On the commission's agenda for this year, Forstein told the Board, are creating linkages with the primary care community, developing additional training guides and clinical materials, cultivating the integration of HIV research and clinical practice, providing guidance to non-medical mental health professionals, and addressing the cultural impact of mental health care.

The project and the commission have organized a full-day program for the APA Institute on Psychiatric Services in October titled "Treatment and Care in the Third Decade of AIDS."

With the Commission on AIDS and the APA AIDS Education Project relying primarily on CMHS grants for their funding, Forstein indicated that a primary goal of the commission is "to more effectively compete for funds to support research and education activities vital to the future of psychiatry." The American Psychiatric Foundation is helping the commission locate and obtain these additional funds to support the new initiatives and continue existing ones.

Information about APA's AIDS programs and about the Practice Guideline for Treating Patients With HIV/AIDS is available on the Web at <www.psych.org/AIDS>. ■

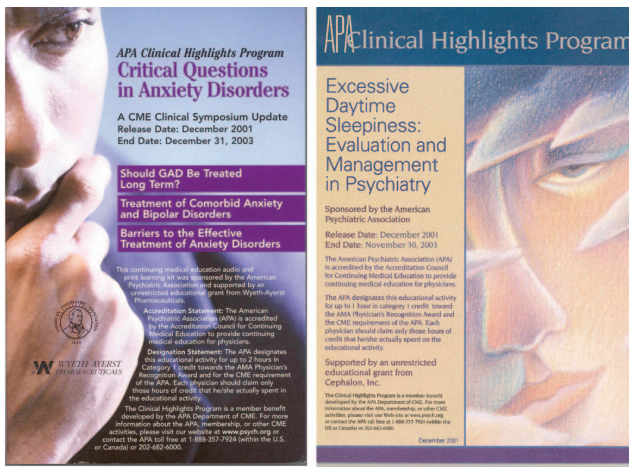
APA Brings Annual Meeting Sessions Directly to Members

APA sends members the two newest editions of its Clinical Highlights series. They focus on evaluating and managing daytime sleepiness and critical issues in anxiety disorders.

APA members who were unable to attend last year's annual meeting in New Orleans now have an opportunity to benefit from the cutting-edge knowledge that was exchanged during one of the meeting's most popular formats.

In December APA mailed all of its members copies of two editions of its Clinical Highlights Program, which summarize presentations of some of the industry-supported symposia at last year's APA annual meeting. One of the two programs is titled "Excessive Daytime Sleepiness: Evaluation and Management in Psychiatry." The presentations in this module focus on neural substrates of arousal and sleep, diagnosing and managing disorders of excessive daytime somnolence, evaluating and measuring daytime sleepiness, and managing symptoms of fatigue and sleepiness in psychiatric patients.

The second program answers "Critical Questions in Anxiety Disorders." Topics covered include the cost burden to patients, families, and society of anxiety disorders; the efficacy of antidepressants and anxiolytics in treating social phobia; whether generalized anxiety disorder should be treated long term; treating comorbid anxiety and bipolar disorders; and barriers to effective treatment of anxiety disorders.



The program is coordinated by APA's Department of Continuing Medical Education (CME), and members can receive CME credit by completing and returning a test and evaluation form included with each entry in the series. They will earn one hour of Category 1 CME credit for doing so.

Programs will soon be available on the CME section of APA's Web site at <www.psych.org/cme> at no charge to members.

The daytime sleepiness program, which members received in the form of a monograph, was supported by an unrestricted educational grant from Cephalon Inc. The anxiety disorders module, which was sent as an audiotape and accompanying booklet, was supported by an unrestricted grant from Wyeth-Ayerst Pharmaceuticals.

APA sponsors the Clinical Highlights series, with the funds administered by the American Psychiatric Foundation.

Before each part of the series is finalized, independent reviewers screen them to ensure that there are no unsubstantiated research claims or bias in favor of a particular company's products. All include references that support research and efficacy claims made by the symposium presenters.

Additional programs in this year's series, all of which will be sent to members by June, are:

- "An Evidence-Based Approach to Pediatric Psychiatry"
- "Psychosis of Alzheimer's Disease: New Knowledge, New Treatment Strategies"
- "Chemical Restraints: Clinical, Research, and Ethical Implications"
- "PTSD: Clinical Characteristics and Treatment Options"
- "Men, Women, and Schizophrenia: Does Anatomy Determine Destiny?"
- "Clinical Challenges in Anxiety"
- "Comparing Atypical Antipsychotic Therapies: Making Sense of the Data"
- "Optimizing Treatment Outcomes in Patients With Chronic Depression"

Additional information about APA's Clinical Highlights Program is available on APA's Web site at <www.psych.org/cme> or by telephone at (888) 357-7924 in the U.S. and Canada. ■

Register Now for Camp APA

If you want your children to have an unforgettable experience during your stay at APA's 2002 annual meeting in Philadelphia next month, be sure to register them for Camp APA. Children up to the age of 17 will be able to participate in a wide range of entertaining activities and see the city with their peers. Camp APA will be headquartered at the Loews Hotel. **The registration deadline is May 6.** More information on fees and field trips and a registration form are posted on the Web at <www.psych.org/sched_events/ann_mtg_02/11-15-child_care_regform.pdf>.

APA's Academic Consortium Heads Up Capitol Hill

Key congressional appropriations committee staffers Craig Higgins and Bettilou Taylor hold their Distinguished Staff Awards from APA "for supporting biomedical and behavioral research funding at NIH." Ellen Murray, not pictured here, also received the Distinguished Staff Award.

Sen. Paul Wellstone (D-Minn.) (right) receives the Academic Consortium Distinguished Legislator Award for "his tireless advocacy on behalf of people with mental illness and addictions" from consortium cochair David Kupfer, M.D.

Academic Consortium participants advocated on Capitol Hill last month for a 16 percent increase in the Fiscal 2003 budgets of the three national institutes that fund a substantial portion of psychiatric and addictions research.

BY CHRISTINE LEHMANN

About 40 professors and chairs of academic psychiatry departments; directors of Veterans Affairs Medical Illness Research, Education, and Clinical Centers; and patient advocates went to Capitol Hill last month to urge Congress to increase federal funding for psychiatric and addictions research.

The message of the Academic Consortium was that the institutes that make up the National Institutes of Health, such as the National Institute of Mental Health, should receive the same increases as NIH in Fiscal 2003.

The Academic Consortium, cochaired by Lewis Judd, M.D., and David Kupfer, M.D., also focused attention on the parity legislation reintroduced in the House last month (see page 16) and increasing the Veterans Affairs biomedical research budget in Fiscal 2003. (APA Medical Director Steven Mirin, M.D., is scheduled to testify on the VA budget this month.)

The trek to Capitol Hill was one highlight of the consortium's two-day activities. Before going to Capitol Hill, participants were briefed by APA staff and had another opportunity to meet with members of Congress and their aides at a reception that evening.

President Bush proposed in his Fiscal 2003 budget to Congress in February that NIH receive an increase of nearly 16 percent, which would double the 1998 funding level (*Psychiatric News*, March 1).

APA supports that $3.7 billion increase in the NIH budget, but is concerned about the approximately $490 million in proposed set-asides and transfers for nonresearch activities, according to Lizbet Boroughs, associate director of APA's Division of Government Relations.

Another concern is that Bush has proposed approximately 16 percent increases for some institutes in Fiscal 2003, such as the National Cancer Institute, but only between 8 percent and 9 percent increases for the National Institute of Mental Health, National Institute on Drug Abuse, and National Institute on Alcoholism and Alcohol Abuse.

"This is the first year that the president's budget has departed from the pattern of giving all the institutes the same increases as the NIH," said Judd at the consortium's meeting at APA headquarters.

At the reception that evening, which was held in the House Rayburn Building on Capitol Hill, the consortium presented awards to a number of people (see photos). Not pictured are Sen. Tom Harkin (D-Iowa), who later received the APA Doubling Award for his "outstanding legislative leadership to achieve the doubling of the federal funding for NIH," and Acting NIH Director Ruth Kirschstein, M.D., who later received the Academic Consortium Distinguished Service Award for "her lifelong commitment to biomedical and behavioral research at the NIH." ■

Rep. Patrick Kennedy (D-R.I.) (right) greets Academic Consortium cochair Lewis Judd, M.D., while APA President-elect Paul Appelbaum, M.D., looks on.

Photos: Marty LaVor

Rep. Marge Roukema (R-N.J.) shares a light moment with consortium cochair David Kupfer, M.D.

Rep. James Moran (D-Va.) (center) enjoys the spotlight with APA President-elect Paul Appelbaum, M.D., and consortium cochair Lewis Judd, M.D.

Rep. Lynn Rivers (D-Mich.) chats with consortium cochair Lewis Judd, M.D., at the reception.

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Hill's Parity Advocates Gird For New Legislative Battle

The first hearing on a reintroduced parity bill in the House reveals how the legislative debate will shape up.

BY CHRISTINE LEHMANN

Advocates of mental health parity in insurance coverage are concentrating their efforts on the House this year, where a new bill was introduced in March by Reps. Marge Roukema (R-N.J.) and Patrick Kennedy (D-R.I.). The Senate passed an identical bill last year (S 543) but it was ultimately defeated as an amendment to an appropriations bill last December *(Psychiatric News*, January 18).

The Mental Health Equitable Treatment Act (HR 4066) requires health plans with mental health benefits to provide the same treatment limits and cost sharing requirements as for other medical benefits. However, the bill applies only to in-network services, exempts businesses with up to 50 employees, and allows health plans to manage mental health care.

If the bill becomes law, it will go into effect next January, when the one-year extension of the 1996 parity law passed by Congress last December expires.

House Republicans on an appropriations conference committee voted against the Senate parity bill last year, complaining that the bill was never heard by House committees that address health issues. These committees are Ways and Means, Energy and Commerce, and Education and the Workforce. Committee chairs were instructed by the House leadership to hold hearings on parity and act on parity legislation this year.

The House Education and the Workforce Subcommittee on Employer-Employee Relations held a hearing on parity in mid-March. Chair Sam Johnson (R-Tex.) said, "The hearing was held to hear the concerns of mental health advocates and allow employers and care managers to explain how the expanded requirements would impact the care they provide."

The Energy and Commerce Subcommittee on Health is expected to hold a hearing on the Roukema-Kennedy bill, which was referred also to the Education and the Workforce subcommittee.

Roukema called HR 4066 a compromise measure because it doesn't cover substance abuse parity as did her 2001 parity bill. In introducing the new bill, Roukema said, "While there are over 203 cosponsors of HR 162 (the Mental Health and Substance Abuse Parity Amendments of 2001), I recognize the political reality that the legislation in its current form is not likely to move forward in the House."

The bill has languished in subcommittees since last May. This year's bill requires a study of substance abuse parity.

However, opponents appear to be more concerned that the legislation mandates parity for all conditions listed in the *DSM-IV*. Health plans that offer mental health benefits only for biologically based illnesses would be required to offer mental health benefits for all conditions in *DSM-IV*, which they argue would be costly.

Kay Nystul, a behavioral health nurse and case manager with Wausau Benefits, testified at the March hearing. "Federally mandated coverage for all conditions in the *DSM-IV* is not the right prescription for effective allocation and delivery of mental health benefits. A clear distinction needs to be drawn between biologically based mental illness and other conditions listed in the *DSM-IV*."

Jane Greenman, vice president and deputy general counsel for Honeywell International, testified for the ERISA Industry Committee that a broad mental health parity mandate "will likely result in increased employee cost-sharing, reductions in other health care coverage, and/or the elimination of mental health coverage entirely."

However, studies of states with laws mandating full parity found that serious mental illnesses accounted for 80 percent to 90 percent of the costs of mental health care, according to Michael Strazzella, deputy director for congressional relations in APA's Division of Government Relations (DGR). "For a fraction more, you can have full parity." Since January DGR staff have been meeting with key House committee staff and legislative aides who focus on health issues to move parity forward in the House this year.

Henry Harbin, M.D., a psychiatrist and CEO of Magellan Health Services, which manages mental health benefits for employees in 29 states with parity legislation and for federal employees, testified that the total health care premium after parity mandates were enacted has not increased above 1 percent. "In fact, our experience is that parity typically increases costs ranging from .2 percent to .8 percent of the health care premium," said Harbin.

The Congressional Budget Office estimated last year that S 543, the companion to HR 4066, if enacted, would have increased premiums for group health insurance by an average of .9 percent, said Harbin.

Many Republican members of the House Education and the Workforce Committee consider parity an issue with potential for bipartisan consensus, if it doesn't endanger health benefits for workers. "If we can work on a bipartisan basis with President Bush and both parties to address the concerns of mental health advocates and employers, then that is what the committee is going to work toward," Kevin Smith, a committee spokesperson, told *Psychiatric News.*

APA's written statement to the House Education and the Workforce Committee on the importance of parity legislation is available online at <www.psych.org/pub_pol_adv/edworkforce.cfm>. ■

Women's Health Issues Get Increased Federal Attention

Women's health advocates in federal agencies are ensuring that programs and studies look at preventing and treating mental illness and substance abuse in women.

BY CHRISTINE LEHMANN

Tommy Thompson, secretary of the Department of Health and Human Services (HHS), recently announced a $2.1 million increase in the Office of Women's Health (OWH) budget for Fiscal 2003, bringing the total to $29 million. Among the program priorities for Fiscal 2003 are expanding services for women who experience violence, eating disorders, and homelessness.

The OWH sets a comprehensive women's health agenda and works with other federal agencies to implement it. These agencies include the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institutes of Health (NIH).

Former President Bill Clinton elevated the OWH within the Public Health Service when he appointed psychiatrist Susan Blumenthal, M.D., as the first deputy assistant secretary for women's health in 1993. She was replaced by Wanda Jones, D.P.H., in 1998.

A priority at OWH is preventing violence against women across the lifespan. Research has shown that women who are victims of interpersonal violence have higher rates of posttraumatic stress disorder (PTSD), depression, anxiety, substance abuse, eating disorders, and multiple personality disorder than women not victimized by violence.

Wanda Jones, D.P.H.: "An interesting research question is whether homeless female veterans have higher rates of PTSD than other homeless women. . . ."

The OWH chairs the HHS Violence Against Women Steering Committee, which coordinates related activities including maintaining the national domestic hotline, funding grants for community responses to domestic violence, and studying the economic and personal costs of violence against women.

Because eating disorders disproportionately affect women and girls, the OWH is partnering with the National Institute of Diabetes and Digestive and Kidney Diseases and the National Heart, Lung, and Blood Institute this year to examine how obesity is linked to eating disorders such as binge eating, said Jones.

"We already know that body image and self-esteem in adolescent girls play an important role in eating disorders," said Jones. The OWH has also formed a partnership with a private foundation to educate the public and health care professionals about eating disorders, she noted.

What about the mental health needs of homeless women veterans? The OWH is collaborating with the Department of Veterans Affairs this year to look at that question and to ensure that HHS programs are available to these women. "An interesting research question is whether homeless female veterans have higher rates of PTSD than other homeless women because of serving in such 'hot spots' as the Persian Gulf and Saudi Arabia," said Jones.

Because the surgeon general's 1999 report on mental health mentioned women's health only briefly, the OWH is developing a special supplement devoted solely to women's mental health, Jones pointed out. This will be a joint effort with SAMHSA and the National Institute of Mental Health (NIMH), said Jones. She anticipates the supplement will be released next year.

Women's Health Research

NIH's Office of Research on Women's Health (ORWH) was created in 1990 to ensure that women and minorities were included in clinical research. The same year, the General Accounting Office (GAO) issued a report finding that NIH was slow to include women in research despite its 1986 guidelines urging greater focus in that area.

Congress in 1993 required NIH to include women and minorities in all human-subject research and in sufficient numbers in large-scale Phase 3 studies to analyze differences in responses to interventions. Phase 3 trials are used to test the efficacy and safety of interventions and have a greater impact than smaller trials on clinical practice and health care policy, explained Mary Blehar, Ph.D., director of women's mental health programs at NIMH.

The GAO reported in 2000 that women made up at least half the subjects in NIH-funded Phase 3 trials. But it found that the number of women in several Phase 3 studies was insufficient to perform accurate gender analyses. The ORWH responded by strengthening its guidelines to require that gender analysis be mentioned in every funding announcement, evaluated by Phase 3 peer reviewers, and included in researchers' progress and final reports.

Good Track Record

The NIMH and the National Institute

see ***Women's Health*** *on page 65*

PRMS

PBW

M.D.s Hope Bill Will Provide Bargaining Power

A new bill backed by the AMA and APA would allow independent physicians to negotiate jointly on their fees and contracts without fear of violating antitrust law.

BY CHRISTINE LEHMANN

Never say die when it comes to bills in Congress. Reps. John Conyers (D-Mich.) and Bob Barr (R-Ga.), who serve on the House of Representatives Judiciary Committee, revived antitrust legislation last month that would allow independent physicians to bargain collectively with health plans.

The House had passed a similar antitrust bill in 2000, but the Senate never took action on it.

Jay Cutler, J.D., director of APA's Division of Government Relations, said, "APA strongly supports the legislation, which would enable psychiatrists to more effectively advocate on behalf of their patients when negotiating with large health plans."

Under the bill, physicians and other health care professionals who are not employed by other entities could band together to negotiate with health plans and hospitals about their contracts and fees when such negotiation would promote competition. Physicians would not be permitted to strike.

If physicians are challenged on whether they exceeded the scope of the law in engaging in collective bargaining, the bill requires that a "rule of reason" standard be applied.

That standard says: "In any action under the antitrust laws challenging the efforts of two or more physicians or other health care professionals to negotiate with a health plan, the conduct of such physicians or health care professionals shall not be deemed illegal per se, but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including patient access to health care, the quality of health care received by patients, and contract terms or proposed contract terms."

The bill calls for the creation of demonstration projects in selected states to test various collective-bargaining models with the goal of enhancing the "efficiency, quality, and availability of health care, while promoting competition in the health care market."

In one model, there would be no restrictions on joint negotiations, excluding strikes and price fixing. Another model would have more government oversight. No state will be permitted to have more than one demonstration project.

The bill would limit antitrust violation damages to actual damages, plus interest. Currently violators must pay three times the actual damages.

"In this era of dominating managed-care health plans, this legislation would bring important relief to patients," said Cutler.

The market power of insurance companies has increased tremendously since the early 1990s, according to a November 2001 study by the AMA. For example, since 1995, 321 managed care mergers and acquisitions have occurred. "This unprecedented consolidation has provided health plans with significant leverage over health care professionals and patients in determining the scope, coverage, and quality of medical care," reported the AMA.

The insurance industry and employers opposed the 2000 bill, and the American Association of Health Plans (AAHP) denounced it as "irresponsible" when it was introduced in March. The AAHP protested that the bill would drive up costs at a time when national spending on health care is already climbing at the fastest rate in more than a decade, according to the March 8 *Congressional Daily Monitor*.

"Our doctors should not face the possibility of criminal prosecution simply for making an effort to improve patient care and limit the financial costs to consumers," said Barr in a press statement. "Yet this is exactly what happened to a group of doctors in Savannah several years ago when they came together in an effort to limit the skyrocketing costs of obstetrical services. Simply by meeting to discuss efforts to reach fair negotiations with the HMOs, the Federal Trade Commission filed civil and criminal actions against them."

The Health Care Antitrust Improvements Act of 2002 can be accessed on the Web at <thomas.loc.gov> by searching on the bill number, HR 3897. ■

Psychiatrists Convince State To Modify Drug Formulary

Thanks to Michigan psychiatrists, officials have made concessions about psychotropic drugs as the state begins implementation of a Medicaid drug formulary.

BY KATE MULLIGAN

Members of the Michigan Psychiatric Society (MPS) helped shape the future of the state's new drug formulary for Medicaid patients by persistence, close attention to detail, and an inclusive approach to solving problems.

The high-profile formulary was touted in the December 7, 2001, *Wall Street Journal* as an "experiment that takes dead aim at the drug companies' freedom to set prices" (*Psychiatric News*, January 18).

A committee of physicians and pharmacists chose so-called best-in-class drugs in 40 categories covering a range of illnesses across all of medicine. The formulary policy stipulated that if a physician wanted to prescribe a drug not on the list, he or she must "call a state technician and get approval," which would be granted only if the drug was considered "medically necessary."

After a legal challenge by the Pharmaceutical Research and Manufacturers of America, the Michigan Court of Appeals on January 18 lifted a circuit court's order that blocked the state from implementing the formulary.

The state contracted with First Health, a pharmaceutical benefits management (PBM) company to administer the formulary for Medicaid fee-for-service patients. The 19 Medicaid HMOs, called qualified health plans (QHP), will administer the formulary for psychotropic classes of drugs for their Medicaid managed-care patients, many of whom receive services from the community mental health program.

"Problems of communication and coordination immediately became apparent," said Jonathan G.A. Henry, M.D., medical director of the Clinton-Eaton-Ingham Community Mental Health Board.

First Health was to begin implementation of the formulary on February 1, but by late February even the steps by which a physician was to request prior authorization were unclear. The process, as outlined by state legislators in a letter of agreement, requires a call to a PBM technician, which can be followed by an appeal to a PBM pharmacist and a subsequent appeal to a physician under contract with the Michigan Department of Community Health.

First Health and many of the 19 QHPs each developed a preauthorization form, which could have resulted in physicians keeping track of 20 different methods for making requests.

Henry said that he and other medical directors of community mental health centers began hearing rumors that primary care physicians were planning to drop Medicaid patients because of the confusion, administrative burden, and need to obtain preauthorization for patients who were stable on nonformulary drugs.

An exodus of those physicians would have taxed the resources of the already burdened community mental health centers.

Henry, other members of MPS, and a coalition representing community mental health centers brought their concerns to state officials.

"We needed to get everyone at the table," he said. "We involved First Health, the HMOs, primary care physicians, hospitals, as well as psychiatrists."

The most significant victory was a grandfathering in of Zoloft, Celexa, Prozac, Luvox, Effexor XR, Aricept, and Durgesic Patch for patients who were using the drugs prior to March 1. State officials were persuaded by the argument that it would be pointless to take a patient off a medication that works well.

A series of meetings resulted in significant progress in terms of administrative procedures and coordination. The medical personnel, for example, pointed out that procedures were necessary to ensure that patients being discharged from psychiatric hospitals were able to continue with their medication.

The collaborative enterprise led to an effort by MPS to explore ways to provide training and education about the use of psychotropic medications. The activities will be targeted to primary care physicians, as well as community mental health psychiatrists.

What can psychiatrists in other states learn from the Michigan experience? "Be proactive and work collaboratively," said Henry.

They may need to apply those lessons soon. In its February 27 edition, the *Wall Street Journal* reported that a formulary similar to Michigan's was part of a budget proposal vetoed by Minnesota Gov. Jesse Ventura (I). The proposal is expected to appear in a later compromise bill.

The National Conference of State Legislatures found that as of October 2001, 26 states had passed some type of pharmaceutical regulation law (*Psychiatric News*, March 1). ■

Psychiatrist Has Ambitious Plans as University President

One APA member plans to take teaching beyond the classroom and create partnerships between academia and the community.

BY EVE KUPERSANIN

A psychiatrist will draw on his years of expertise in human learning to lead Case Western Reserve University (CWRU) into the future.

Edward M. Hundert, M.D., is leaving his post as dean of the University of Rochester School of Medicine and Dentistry to become president of CWRU on August 1.

Hundert is a psychiatrist and educator who, before his appointment as dean of the University of Rochester School of Medicine and Dentistry in 2000, served as the senior associate dean for medical education since 1997. He is also a professor of psychiatry and medical humanities at the University of Rochester.

While most medical students have two years of basic sciences followed by two years of clinical medicine, Hundert devised a curriculum that integrated the basic sciences and clinical medicine throughout the four-year program. He compared his plan to the double-helix structure of DNA: Like a molecule of DNA—which has two strands of nucleotides that parallel each another—students study scientific theory and clinical medicine simultaneously.

"I believe that by getting the students involved with real-world experiences with sick people before most would say they were ready, they are then driven to learn the theory behind the medicine," Hundert said in an interview.

Edward Hundert, M.D.: "We can weave experience and theory together in all of education."

Before coming to the University of Rochester, he was associate dean for student affairs at Harvard Medical School from 1990 to 1997 and was an associate professor of psychiatry from 1994 to 1997.

Hundert was involved in the formulation of medical ethics while at Harvard. In 1988 he became hospital ethicist at McLean Hospital, where he chaired the McLean Hospital Ethics Committee from 1992 to 1997. Hundert also served as chair of the Massachusetts Psychiatric Society Ethics Committee from 1992 until 1997. Last year he became chair of APA's Task Force to Update the Ethics Annotations.

A prolific author, Hundert has written articles and book chapters on topics related to psychiatry, philosophy, medical ethics, and medical education. He also wrote two books, *Philosophy, Psychiatry, and Neuroscience: Three Approaches to the Mind*, published by Oxford University Press in 1989, and *Lessons From an Optical Illusion: On Nature and Nurture, Knowledge, and Values*, published by Harvard University Press in 1995.

As president of CWRU, Hundert plans to apply the principles behind the "double-helix" curriculum on a larger scale. "We can weave experience and theory together in all of education," he said. "For instance, anthropology majors could go to culturally diverse areas in the community and gain real experience with different cultures."

Hundert said that one thing that attracted him to the presidency of CWRU was that the faculty had already engaged in discussions about the relationship between experiential learning and the learning of theory.

"The students could then access the research laboratories, businesses, and cultural institutions of Cleveland—all places where life experience would then become the hook for them to learn rigorous theory."

Hundert also would like to link academic programs at CWRU to the community to benefit both the students and community. For instance, "science or engineering students might work in the academic or industry laboratory, music students would become involved with the music community, and an anthropology student would work in a culturally diverse community agency."

"We need to think about the responsibility of a national and international research university such as CWRU to the city it shares—Case Western is poised to link its academic enterprise to the city of Cleveland," said Hundert, "and Cleveland is also poised to link with the university."

To that end, Hundert has held talks with Cleveland Mayor Jane Campbell and many of the city's business leaders about developing new partnerships and "technology-transfer" opportunities. He said that he would like to see advances in science, technology, and medicine developed at CWRU become patented and licensed technologies.

"By combining the talents of our faculty with the complementary talents found in many of the businesses in Cleveland, we would like to move these discoveries into practical advances that can help humankind and also power the economy of northeastern Ohio."

Hundert also plans to build upon his work in ethics as head of the Midwestern university and said that all aspects of education "should develop one's critical and intellectual skills to prepare them to be able to recognize and make" sound judgments.

Hundert said that he had to stop seeing patients five years ago to take on the demands of a full-time administrative leadership position. His training and experience in psychiatry, however, have prepared him well for his new appointment.

"When trying to be an agent of positive change in a world of conflict where emotions can often cloud judgment, it helps to have training geared specifically at managing these types of issues," he said. ■

Disability Policy Discrimination Lands Employer in Court

A former Fannie Mae employee with bipolar disorder wins a lawsuit in February after challenging the definition of mental illness in the company's disability plan.

BY CHRISTINE LEHMANN

The lack of parity in her employer's disability insurance benefits drove Jane Fitts to sue her former employer, Federal National Mortgage Association (Fannie Mae). She won her case in February against the mortgage giant and its disability insurer Unum Life Insurance Company of America. The defendants plan to appeal the ruling.

Fitts, an attorney employed by Fannie Mae in the District of Columbia since 1982, was diagnosed with bipolar disorder in 1995. Unable to work, she applied for disability benefits, which she received for two years. However, she protested to Unum that it had unfairly terminated her benefits at the end of that period. She claimed her bipolar disorder should have been classified as a physical illness, which would have entitled her to receive benefits until she was age 65. Unum disagreed, and Fitts filed suit against Unum and Fannie Mae in 1999 in U.S. District Court for the District of Columbia.

Fitts claimed that the defendants violated the Americans With Disabilities Act of 1990 and the Employee Retirement Income Security Act (ERISA) of 1974. The court dismissed the ADA Title I claim, finding that Fitts was ineligible to sue because she was not a "qualified individual with a disability," but totally disabled and unable to work, according to the 1999 ruling. The court also dismissed Fitts's ADA Title III claim because the long-term disability policy was not "a good or service provided by any place of public accommodation."

Fitts's ERISA claim was heard by the court because a legal provision entitles a plan participant or beneficiary to "recover benefits under the terms of the plan," according to the ruling.

The court upheld Unum's classification of Fitts's bipolar disorder as a mental illness. Fitts appealed her case to the U.S. Court of Appeals for the District of Columbia Circuit, which found that the lower court used a standard that was favorable to the employer. The appellate court sent the case back for a second review under a neutral standard.

Problem of Definition

Fitts v. Federal National Mortgage Association, et al., turned on Unum's definition of mental illness in its disability policy under Fannie Mae's benefit plan as a "mental, nervous, or emotional disease or disorder of any type."

A legal doctrine *(contra proferentem)* requires ambiguous contract terms to be interpreted against the drafter, which in this case was Unum and Fannie Mae.

ERISA, which regulates employee benefit plans, requires insurance policies to be written in a manner that can be understood by the average plan participant, according to the February court opinion.

Fitts argued that that the plan's definition of mental illness was ambiguous and that bipolar disorder was excluded based on its physical characteristics.

She presented brain scans of the parietal lobe in the left side of her brain that showed atrophy compared with brain scans of a healthy person her age.

Bipolar-disorder expert Frederick Goodwin, M.D., stated on behalf of Fitts that bipolar disorder is a neurobiological disorder that affects the physical and chemical structure of the brain. He testified that bipolar disorder is a physical illness because "it afflicts the brain, which is a physical organ of the body," according to the court opinion.

Fitts's treating psychiatrist, Suzanne Griffin, M.D., also stated that bipolar disorder causes physical changes in the brain.

The defendants countered that bipolar disorder is a mental illness, rather than biological, and is recognized in *DSM-IV*, which is widely accepted as the "official nomenclature of mental disorders."

Peter Mirkin, M.D., a psychiatrist employed by Unum, also stated that bipolar disorder is typically treated by psychiatrists using psychotherapy and psychotropic drugs. He cautioned that biological markers were insufficient to characterize bipolar disorder as a physical illness because "all illnesses recognized in *DSM-IV* may correlate with biological changes."

U.S. District Court Judge Henry Kennedy agreed with Fitts's assertion that Unum's definition of mental illness was ambiguous, because the expert witnesses disagreed on the definition based on different interpretations of the biological and psychological factors.

Reactions to the Ruling

Ron Honberg, J.D., legal director of the National Alliance for the Mentally Ill, told *Psychiatric News*, "The decision has more symbolic than far-reaching significance. It would have more impact if the court had ruled that Fannie Mae and Unum violated the ADA [because] Unum, the largest long-term disability insurer in the nation, would have been required to change its discriminatory policy."

Renee Binder, M.D., chair of APA's Commission on Judicial Action, commented to *Psychiatric News*, "The decision was positive in that the court understood that bipolar disorder is a brain-based illness and that people with the disorder are entitled to long-term disability benefits. But the fact that that disability insurers distinguish between physical and mental disorders shows they don't recognize that they are equally disabling."

Mary Giliberti, J.D., senior staff attorney at the Bazelon Center for Mental

see ***Lawsuit*** *on page 25*

Insanity Standards May Vary, But Plea Rarely Succeeds

Addressing the shortcomings of the insanity defense throughout the United States may be less important than public education about mental illness.

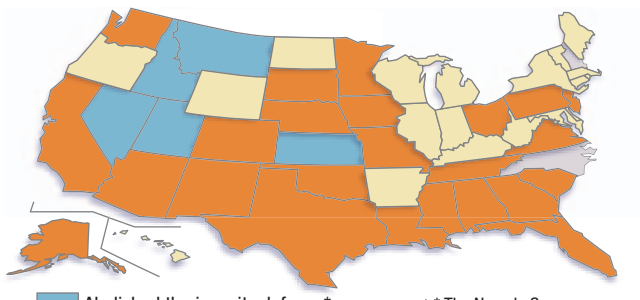
BY MARK MORAN

For nearly two centuries, American society has struggled with how to administer justice to people who are deemed to be significantly mentally ill when they commit a criminal act.

And some experts say the guilty verdict rendered in Texas last month against Andrea Yates, who drowned all five of her children in a bathtub, demonstrates the extreme difficulty of proving a defendant not guilty by reason of insanity even when few doubt that the defendant is severely mentally ill.

"There are good studies showing that a successful insanity defense occurs in less than 1 percent of all criminal prosecutions," said Jeffrey Metzner, M.D., immediate past president of the American Academy of Psychiatry and Law (AAPL) and chair of APA's Council on Psychiatry and the Law. "If Andrea Yates wasn't found legally insane, you know it's pretty difficult to find anyone not guilty by reason of insanity."

One indication of the problems with the insanity defense is the variations and permutations in the way states apply the insanity defense.



Yates was found guilty in a state that applies the M'Naghten Rule—an insanity definition formulated in 1843 and derived from English case law. That rule states that a person is "innocent by reason of insanity" if "at the time of committing the act, he was laboring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know that what he was doing was wrong."

Because the jury was convinced that Yates knew that what she did was wrong, statutory law demanded a guilty verdict.

New Practice Guidelines

In June AAPL will issue "Practice Guidelines for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense." The 60-page document will include a survey of states and their standards regarding the insanity defense (see map).

According to Howard Zonana, M.D., medical director of AAPL, Texas is joined by 24 other states in using the M'Naghten Rule, or some variation of it. Some of those states—but not Texas—add a reference to "irresistible impulse," allowing defendants to be considered not guilty by reason of insanity if they could not resist the criminal act, even if they knew it to be wrong.

Nineteen states and the District of Columbia apply a definition formulated by the American Law Institute (ALI) in the 1950s, or some variation of that definition. The ALI definition, allowing a somewhat broader understanding of insanity, holds that a person would "not be responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law."

> **"When you have a strict M'Naghten standard, you don't get into the balancing of how delusions are affecting your thinking."**

One state—New Hampshire—applies a "product test," which requires juries to determine whether a criminal act was the "product" of mental illness. And five states have abolished the insanity defense altogether, according to Zonana.

An Ideal Standard?

Surely, in another state not ruled by the strict M'Naghten standard, Andrea Yates might have had a chance at a not-guilty verdict. "When you have a strict M'Naghten standard, you don't get into the balancing of how delusions are affecting your thinking," Zonana said. "As long as you can say she knew it would be illegal, the state law demands a guilty verdict."

But experts note that the varying statutes are legal formulations—not medical ones—designed by legislatures to guide judges and juries in making what are invariably moral judgments. While psychiatrists who have examined a defendant may render opinions

about mental health or illness, they do not have the expertise to render legal judgments, let alone moral ones.

As Metzner noted, even among psychiatrists there are bound to be differences about any particular standard. "Asking people about the insanity defense is like asking them about capital punishment," he said. "When you look at the insanity defense among psychiatrists, you are going to get a wide variety of opinions, and some would be opposed to it altogether."

Legal standards reflect a shifting moral consensus among the public. "For many years books have been written and debates held about what is the best standard for an insanity defense," said APA President-elect Paul Appelbaum, M.D. "There was a fairly broad consensus in the middle of the 20th century that the M'Naghten standard was too narrow."

It was that consensus that led to the ALI standard, which broadened the definition under which a defendant could be found not guilty. But the consensus shifted again with the case of John Hinckley, who shot former President Ronald Reagan and was found not guilty by reason of insanity. "After the Hinckley verdict, there was a swing back away from a broadened standard to a narrower standard," Appelbaum said.

Appelbaum suggested that ultimately the legal language used in statutes is subservient to the moral judgments that 12 men and women make in a jury room.

"It is clear that when juries are asked to consider the insanity defense, they are doing something much more than simply applying the legal standard that is handed to them," Appelbaum said. "They are making a moral judgment as to whether punishment is deserved. That's a reasonable function, and I think it is precisely what we should ask our juries to do—to represent our morality at large.

"One would hope that they would exercise that function with good background knowledge and a full awareness of the facts about mental illness," he said. "Clearly, that's not always the case because our juries share the popular misconceptions about the nature of mental illness."

Photo: AP/World Wide Photos

Andrea Yates is escorted from court after being arraigned before State District Judge Belinda Hill in a Harris County, Tex., court room in Houston on June 22, 2001.

He noted that in published studies of mock juries given case scenarios and asked to render judgments using a variety of standards, juries tend to come to the same conclusion regardless of the standard.

"In some abstract sense, it doesn't seem to make much difference what the standard is," he said. "It's pretty clear to me that in most cases what goes in a jury room is that the jurors do what they think is right."

While deterrence is a legitimate function of the law, so it seems is retribution. "It seems inherently just to our society to punish people for the violation of social norms," he said. "The worse the violation, the stronger the impulse to punish. Whatever we do with the standards is not going to change that dynamic."

Ultimately, then, fine-tuning legal statutes may be of little use in achieving justice for mentally ill defendants.

"If we want to change what goes on in the jury room and ensure that it reflects an accurate view of mental disorders," Appelbaum said, "the way to do that is through public education." ■

Lawsuit

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Health Law, told *Psychiatric News* that Fitts wouldn't have had to file the lawsuit if there was parity in disability benefits.

"Employees should only have to prove that they are too disabled to work," said Giliberti, who has represented numerous people with mental illnesses in disability cases. "The limitation on disability benefits can be devastating. One client of mine committed suicide when she found out about her limited benefits, and another client had to foreclose on her home," said Giliberti.

Honberg said, "Most people assume that their long-term disability benefits apply to mental illnesses and physical illnesses. But that is rare."

Indeed, it took NAMI two years to find a long-term disability insurer that offered the same benefits for "mental" and "physical" illnesses, said Honberg. NAMI did find one in 1998, and employees have had to pay a slightly higher premium for the policy. For example, an employee earning $36,000 annually paid $5.59 a month under the old plan, which offered two years of mental disability benefits; since 1998 that same employee pays $6.67 a month—a difference of $12.96 a year, said Honberg.

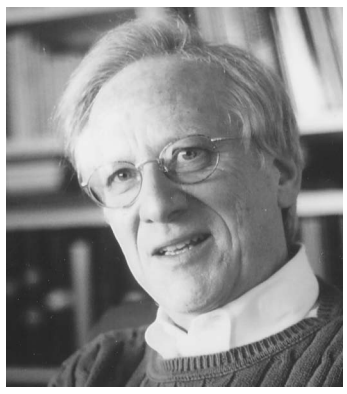
"The bottom-line is that employees should decide whether parity in disability insurance is worth paying slightly higher premiums for," said Honberg.

The lawyers agreed that parity in disability insurance needs to be addressed at the federal and state levels. Honberg testified in 1999 before a Maine banking and insurance committee that was debating a measure that would mandate disability insurance parity. Although the committee was informed about NAMI's relatively small premium increases, the measure did not pass because opponents claimed it would lead to much higher premiums, said Honberg.

The opinion of the U.S. Court of Appeals for the District of Columbia Circuit in the Fitts case is posted at <www.ll.georgetown.edu/Fed-Ct/Circuit/dc/opinions/99-5327a.html>. ■

Letter From Rwanda

BY HARVEY WEINSTEIN, M.D., M.P.H.



Over the last five years I have been immersed in death and rebirth. The experience has forced me to hear stories of pain, to view scenes of wanton destruction and horror, and to confront my own reactions to desperation, hopelessness, and incredible resilience.

In this work, medical school and residency offer little in the way of knowledge or skills. The psychopharmacological armamentarium, sophisticated PET scans, and, especially, *DSM-IV* provide few tools to help us understand how people can go on with their lives after witnessing mass death or to assist them in this task.

Unfortunately, the on-the-job training required has no lack of laboratories or teachers, as my colleagues and I have learned as we engage in a process of trying to understand "ethnic cleansing" and to develop some comprehension of how those whose neighbors turned on them in a murderous rage can learn to live again with those who betrayed them.

Many in the mental health, legal, and diplomatic professions talk about reconciliation. We read and hear about "healing" and "closure" as though the wounds of genocide can be magically transformed into opportunities for personal growth.

In fact, we know little about the rebuilding of societies after war tears them apart and even less about the forging of a process of reconciliation when neighbors have slaughtered neighbors. Trying to make sense of these events is difficult, and in truth, no answers are found in traditional peacebuilding mechanisms, in restoration of the "rule of law," or in conceptualizations of massive psychic trauma.

Last November I was in the central African country of Rwanda—a land of immense beauty. Yet, for those Americans who think about the country at all, Rwanda is a slaughterhouse—the scene of genocide and the murder of more than one million people in little more than 90 days. The profound discrepancy between images of people being hacked to death with machetes and this beauty provides a haunting backdrop as I talk to students, academics, people from the international nongovernmental organizations, and especially the farmers, shopkeepers, and those who struggle daily merely to survive.

I am struck by the gentleness and grace of the people. In the early morning, I walk along the road to Butare from the guesthouse where I am staying. Across the road I see four women wrapped in brightly colored cloth. Each of them has a baby strapped to her back, and I can see little heads emerging from the wrappings, like baby birds peeking over the edge of a nest. When they spy me, the mothers begin to chirp at me in Kinyarwanda, waving and smiling as they shout "Mzungu" (white man). I wave back, and immediately I am surrounded as they cross the divide and circle around me laughing. They want me to touch their babies. (Do I have some magical powers?) Then on they go, smiling and waving goodbye.

In a village school, the students are clapping loudly and chanting as four of their friends dance to the beat of the moving hands. The formality of their blue uniforms and the gray habits of the teaching sisters offer a sharp contrast to the exuberance with which they play the game. When they see a colleague and me approach, they stop suddenly and begin to giggle. With youthful energy, they all begin to wave. I wonder what happened to their families in 1994.

And finally, I go with some friends to a memorial site, an abandoned school, near Gikorongo. Here there are no stone monuments, no statues of generals on rearing horses, no cenotaphs with an everlasting flame. Inside, resting on tables, I see hundreds of skeletons—bones bleached white by lime. I see couples with their arms around each other; I see mothers and babies; I see little children, their arms flung over their faces (were they trying to blot out the horror before they died, or were they trying to protect themselves from the inevitable blows?). Some of the dead still wear shreds of clothing—odd pieces of civilization in a scene of primitive savagery.

Our guide takes us to a mass grave where there are 1,800 bodies. I look around and see the hills, the lush green of the fields, the blue of the sky, and I cannot fit the pieces together. We are silent in the car as we return to the university.

And so we struggle to make sense of reconciliation. The reality on the ground is often very different from the high-flown words of the peacemakers. Once again, I discover how similar we are across cultures—in aspirations, in mourning, and in trying to understand the past.

I conclude that there is no such thing as "coming to terms" with genocide or achieving "closure" after it. There is only the aching pain of lost communities and a life that no longer exists. Yet we continue to search for an understanding of slaughter—something that may be beyond understanding—and we look to see how those who are like us, and yet so different, go on. ■

Dr. Weinstein is associate director of the Human Rights Center at the University of California, Berkeley, and a clinical professor in the School of Public Health.

Parity Is Also a State Issue!

BY MARTY LUSTER

If "conscience (meaning reflection) doth make cowards of us all," those who reflect only on their own political security are cowards of the first class. I refer to the display of cowardice by Republican members of the House-Senate conference committee on the Labor, Health and Human Services, and Education appropriations bill on December 18.

The House conferees defeated, by straight party-line vote, an effort to include the mental health parity amendment championed in the Senate by Sens. Pete Domenici (R-N.M.) and Paul Wellstone (D-Minn.). The amendment would have prohibited discriminatory and unequal insurance coverage for mental illness treatment compared with that for physical illnesses.

Passage of the bill would have been a giant step toward the elimination of the stigma attached to mental illness and a recognition that many who are mentally ill can be treated and often cured and should be treated no differently from those with broken bones or cancer.

This vote occurred even though 244 members of the House of Representatives had indicated their support for the amendment by cosponsoring parity legislation or signing letters urging the inclusion of the Senate amendment in the final appropriations bill.

Clearly, the 10 House Republicans who scuttled this effort, which enjoys enormous support by the American public, were under great pressure from the House Republican leadership who, in turn, caved in to the demands of the insurance industry and big business.

After the vote, all that was left standing was a one-year extension of the current ineffectual federal parity legislation that was passed in 1996. Shame on the Republican leadership in the House and shame on those members who lacked the courage to enact a measure that provides fairness and equity to the 20 percent of Americans who, at one time or another, suffer from serious mental illness.

Given the lack of backbone demonstrated by these members of Congress, it now falls to those states that do not have comprehensive parity legislation in place to enact such measures as soon as possible.

In the 2001 session of the New York State Assembly, I introduced the Fair Insurance Act of 2001 (A 4506). This bill, if enacted into law, will eliminate discriminatory insurance coverage for mental health and substance abuse services. It mandates coverage for those illnesses and requires that the coverage be provided on the same basis as coverage for physical ailments.

It passed the Assembly in March and is now before the Senate Insurance Committee. The Senate sponsor is Sen. John Marachi (R).

Many of the same bogus arguments that were made to defeat the federal Domenici-Wellstone amendment were also used in Albany during the pendency of the N.Y. parity bill in the Assembly. We were regaled with claims that the cost of insurance coverage would skyrocket, ultimately resulting in fewer people being able to afford insurance altogether. This claim is nothing but a scare tactic by the insurance industry and is belied by all objective proof. Maryland, Minnesota, North Carolina, and Texas have all enacted parity legislation. Maryland experienced an initial increase and than a subsequent reduction to pre-parity levels. In Minnesota, one of the large insurance providers reported that the requirement would add only 26 cents to the monthly premiums paid by the 460,000 people enrolled with the company. After implementation of mental health parity for all North Carolina state employees, the state experienced a 32 percent reduction in the per member/per month cost of mental health services over a five-year period. Similarly, Texas experienced a more than 50 percent drop in the per person/per month costs when parity for state employees was enacted.

A parity study was commissioned in New York, and PriceWaterhouseCoopers has issued a preliminary report on the estimated costs of enacting this law. It estimated an increased cost of $1.26 per insured person per month—highly affordable and far from the insurance industry's doomsday projections.

If we can make mental health and substance abuse services readily available to all insured individuals, many often disabling disorders can be diagnosed and treated earlier, thus placing less burden on public resources, businesses, and individuals themselves.

Now that the Fair Insurance Treatment Act of 2001 has already passed the New York State Assembly, and with the failure of parity legislation at the national level, it is imperative that the New York Senate hear from mental health consumers, their supporters and families, clinicians who provide such services, and the rest of us who, in all likelihood, in our lifetimes, directly or indirectly, will be affected by mental illness or substance abuse.

This year must be the year New York State enacts meaningful parity legislation, and it must be the year that we, as a nation, hold politically responsible those who shamefully traded the welfare of 20 percent of the American population for the wishes of the insurance industry. ■

Assemblyman Marty Luster chairs the New York State Assembly Committee on Mental Health, Mental Retardation, and Developmental Disabilities.

States Turn to External Review, But Few Patients Follow

In the absence of a federal Patients' Bill of Rights, most state legislatures established external-review panels to protect consumers from unfair denials of care. How are they working?

BY KATE MULLIGAN

Establishment of external review panels seems like a logical approach to the problem of resolving disputes between health plans and the consumers they insure.

In fact, by the end of 2001, 41 states and the District of Columbia had enacted external review laws, with 27 of them becoming effective in the past three years.

Last session, Congress considered patients' rights legislation that would establish a federal right to external review for all private health plan enrollees. This federal right would have extended external-review protection to people who are not subject to state external-review programs, including enrollees of self-insured employer health plans (47 percent of all employees with group health coverage), which are exempt from state regulation, and residents of states with no external-review laws.

Key questions at this point are, Have these laws and other provisions for external review lived up to their promise, and does review of mental health benefits pose any special problems?

Few Using External Review

The Kaiser Family Foundation commissioned researchers at Georgetown University's Institute for Health Care Research and Policy to assess the impact of state external review programs.

In a study released in March, they reported that consumers were granted relief through external review about half of the time they chose to invoke it. Rates ranged from a low of 21 percent in Arizona and Minnesota to a high of 72 percent in Connecticut.

Caseloads, however, were very small. In New York, 902 consumers filed for review in the reporting year ending June 2000. That figure was more than double that for any other state. Still, it represented far less than 1 percent of covered lives in the state.

According to the researchers, many of the external review programs have features that inhibit access. All but one of the states studied require consumers to first exhaust their health plan's internal appeals and grievance procedures before seeking external review.

There is evidence, however, that consumers do not complete the internal-review process, which often requires three levels of appeal. For example, in Pennsylvania from January 1999 through September 2000, consumers appealed almost 8,200 health plan denials. Health plans upheld 4,469 denials at the first level of appeal, but only 1,062 consumers filed level 2 appeals. At level 2, health plans upheld 618 denials, but only 124 consumers then filed for external review.

Claims Review Problems

Winifred S. Hayes, president and CEO of HAYES Plus Inc., told an audience in February at the National Policy Conference at the American Association of Health Plans (AAHP) in Washington, D.C., "Mental health is a particularly challenging area because of the perception that there is less evidence-based research for mental health treatment than for other areas of medicine."

HAYES Inc. is one of a growing number of Independent Review Organizations (IROs) that conduct reviews at the request of an insurance company or a state agency responsible for administering the law mandating external reviews.

In an interview with *Psychiatric News*, Hayes said that mental health also differs from other areas of medicine because of the impact of safety issues on the determination of medical necessity for treatment approach and setting. "Consideration of the likelihood of suicide or homicide becomes very important when making determinations about inpatient [psychiatric] treatment," she explained.

Benefit definitions can also complicate the review process. In one case, two doctors on a review panel argued successfully for an inpatient stay that exceeded the number of allowable days for mental health treatment for a woman with postpartum depression by saying that pregnancy is a medical condition and, therefore, not subject to the restrictions for mental health coverage.

Hayes noted a "troubling trend" for health plans to specify the number of treatment days covered rather than to use medical necessity as a determining factor for treatment. Companies are better able to control financial and legal risk by using a time-specific method of determining benefits, but when that happens, said Hayes, "we lose flexibility, and patient care can suffer."

Susan Prest, president of Prest and Associates, an IRO that focuses exclusively on review of mental health claims and other mental health care services, speculated that the appeals process might be underutilized for mental health and substance abuse cases because of stigma. "Each level of appeal means that an additional set of reviewers has access to personal details about those illnesses," she said.

Bettina Kilburn, M.D., Prest's medical director, said that although treatment guide-

see ***External Review*** *on page 68*

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Geriatric Psychiatry Group Declares Itself 'Grown Up'

Celebrating a busy year of "stumping" for older Americans with mental health concerns, AAGP's president turns the helm over to a well-known psychiatric educator.

BY JIM ROSACK

A sense of celebration and accomplishment was evident at the American Association for Geriatric Psychiatry's (AAGP) recent annual meeting, much akin to that felt by teenagers as they get their driver's license or voter registration—a certain feeling of "coming of age."

After an intense year of fervent advocacy efforts on behalf of older Americans with mental illness, the organization declared itself "grown up" and ready to assume the lead in geriatric mental health issues.

"I think AAGP is the leader in geriatric mental health care," said Gary Kennedy, M.D., AAGP's incoming president, during his inaugural address. "And I think it's about time we acknowledge that. This is no longer an organization in its adolescence."

That air of confidence was warmly welcomed by those in attendance, after several successive years in which incoming presidents challenged the organization, on one front or another, to become more fully developed, more well rounded, more grown up.

One year ago, then outgoing president William E. Reichman, M.D., recalled how he had used his presidential term to challenge the organization. He had told the group that the organization was not fulfilling its full potential, and it had to bring greater visibility to the field of geriatric psychiatry (*Psychiatric News*, April 20, 2001).

Stephen J. Bartels, M.D.: "AAGP has taken a major step toward fulfilling its potential as the preeminent voice in the field of . . . geriatric psychiatry."

Reichman did just that, conducting one interview after another during his term, with broadcast, newspaper, and magazine journalists.

With that increased visibility in place, Stephen J. Bartels, M.D., who succeeded Reichman as AAGP president, set out to confront the "public health crisis" that he said would result from a "failure of research on health services infrastructure necessary to address the needs of a rapidly growing population of older persons with mental disorders."

At AAGP's February meeting in Orlando, Bartels closed his presidential term by declaring, "AAGP has taken a major step toward fulfilling its potential as the preeminent voice in the field of geriatric mental health and geriatric psychiatry." The organization had "made a difference," he said in his presidential plenary address, "by fostering research, knowledge development, education, and financing on behalf of effective treatments and services for older persons with mental disorders."

Three-Part Strategy

A year ago, Bartels saw troubling trends, such as a decline in funding for geriatric mental health research, Medicare payments for mental health services being attacked as being "largely medically unnecessary," and the proportion of Medicare expenditures spent on mental health effectively decreasing.

"Based upon these alarming trends," Bartels said, "we set about a three-part strategy to aim the spotlight on these concerns."

First, AAGP focused on making geriatric mental health research a federal legislative and regulatory priority. In testimony before Congressional appropriations subcommittees, Bartels called attention to the need for increased funding on mental health and aging.

AAGP was successful in having language adopted in appropriations bills that drew attention to the need for the National Institute of Mental Health (NIMH) to devote additional resources to extramural research in the geriatric area and cited a need for the NIMH to coordinate its research agenda on aging. In addition, language was included in an appropriations bill calling for the inclusion of specialists with expertise in geriatric mental health to be added to the review panels of the institute's studies section.

AAGP also successfully advocated for an additional $5 million in funding for the Center for Mental Health Services (CMHS) to support implementation of evidence-based geriatric mental health practices in primary care settings.

At AAGP's urging, both NIMH and the Substance Abuse and Mental Health Services Administration (SAMHSA) have initiated formal strategic-planning efforts focused on future services-related research in the aging field.

AAGP set its second part of its strategy in play by working with the offices of Sen. Paul Wellstone (D-Minn.) and Rep. Pete Stark (D-Calif.) on increasing awareness of the inequities in Medicare funding of mental health services.

*see **AAGP** on page 68*

NIMH Head Promises More Support for Geriatric Psychiatry

Declaring geriatric psychiatry a "high-need field," the NIMH's acting director throws the agency's support and funding firmly behind efforts to increase the field's research and education programs.

BY JIM ROSACK

Richard Nakamura, Ph.D., acting director of the National Institute of Mental Health (NIMH), declared to a gathering of geriatric psychiatrists in February that even though medicine is in a perilous state, his agency is committed to assisting geriatric psychiatry with increased technical and financial support.

"You come up with the ideas, and we have the money," said Nakamura in the keynote address at this year's American Association for Geriatric Psychiatry (AAGP) annual meeting. "The AAGP has been quite effective in influencing our perspective and getting us to rethink what we were doing in the area of geriatric psychiatry."

Nakamura was appointed acting director of NIMH after the resignation of Steven Hyman, M.D., who left late last year to become provost at Harvard University. Nakamura, a behavioral neuroscientist whose doctorate is in psychology, has worked at NIMH since 1976. Most recently he was director of science policy and planning.

Nakamura acknowledged what he called a "federal health leadership crisis," noting, in addition to Hyman's departure, the resignations of the directors of both the National Institute on Alcoholism and Alcohol Abuse and the National Institute on Drug Abuse. Along with the long-vacant directorship of the National Institute of Neurological Diseases and Stroke, he said, "this leaves four neuroscience institutes without directors, and still there is no sign that they will be replaced anytime soon."

In addition to leadership problems, Nakamura said, NIMH is anticipating, based upon President George W. Bush's budget proposal, what would amount to a relative decrease in funding for mental illness treatment programs, continuing a long trend. Although the Bush administration's budget request includes increases for total funding for NIH, continuing a commitment to double its overall funding, NIMH is receiving proportionately less money from the National Institutes of Health (NIH), its parent agency, to fund mental health treatment programs. "With even generous estimates," he said, "over the last 10 years, the real funding in this area has decreased by half."

Funding of research and training programs has not fared much better, he noted. In 1992, he said, NIMH funded 341 research fellows. By 2000, that number had decreased to 210. "It doesn't take very long to conclude that the number could conceivably go to zero."

"Despite all this," Nakamura declared, "I am here to tell you that the outlook is really pretty good."

Nakamura cited NIMH's active participation in the surgeon general's reports on mental health over the last few years, detailing that mental illness is mediated by the brain, affects overall health, and is highly amenable to treatment.

"These are very stark messages that we have to take out and use over and over again," Nakamura urged, "until we convince the public as well as our legislators and those who control the purse strings of medical compensation that it is true."

Nakamura pledged continued NIMH support for the Institute of Medicine's study of psychiatric training, looking at "how can we make that course of study simultaneously more effective and less time consuming." The NIMH is continuing its work with the Residency Review Committee in Psychiatry to look at not only how to improve training overall, but how to allow a research track as well.

Richard Nakamura, Ph.D.: "AAGP has been very effective in influencing [NIMH's] perspective."

Nakamura announced that the institute is about to come out with a new series of education research grants that will allow psychiatry departments to apply for unrestricted grants to improve psychiatric education, training, and research.

In addition, Nakamura announced that NIMH will declare the field of geriatric psychiatry as "high need." This will allow the institute to increase significantly its funding under the NIH's loan-repayment program.

"And finally, you [AAGP] had asked us to find a way to emphasize geriatric psychiatry or aging within NIMH, so I am announcing tonight the formation of the NIMH Aging Consortium," he said. The consortium will identify and clarify pathways for research funding through NIMH and will be responsible for proposing initiatives in geriatric psychiatry to the NIMH director.

The NIMH Web site is <www.nimh.nih.gov>. ■

Analysts and Authors Share Search for Insight

Psychoanalysts and authors of fiction share an important characteristic: they deal with the depths of the psyche.

BY ANN VAESSEN

The novelists Robert Stone, Denis Johnson, and Jim Shepard joined a trio of psychoanalysts at the New York University (NYU) School of Medicine in February to discuss creativity and imagination in the aftermath of September 11. The session, titled "The Apocalyptic Imagination: Daydreaming in an Era of Nightmares," combined literary delight with a rare opportunity for the public to understand what clinical psychoanalysis is about.

At this installment, the fiction writers, all of whom write on apocalyptic themes, read excerpts from their works, and the analysts—Shelley Orgel, a psychoanalyst and clinical professor of psychiatry at the NYU School of Medicine; Salman Akhtar, a professor of psychiatry at Jefferson Medical College; and Jane Kite, a training and supervising analyst at the Psychoanalytic Institute of New England—commented on what they had heard from a psychoanalytic perspective.

The program, which attracted about 300 attendees, was sponsored by the Psychoanalytic Association of New York, the American Psychoanalytic Foundation, and the NYU Psychoanalytic Institute.

In a relaxed and witty atmosphere, the writers and the analysts told the audience about their perpetual endeavor to find the right words to express intense and troubling feelings and to reflect internal experience.

"They pull in every possible resource to explain the inexplicable, the fissures, the skids, and explosions in our lives. They turn the inside out; they use the external meticulously to make sense of the internal," explained Jane Kite in her analysis of Jim Shepard's short story, "Love and Hydrogen."

In response to Orgel's analysis of a passage from his best-selling novel *Outerbridge Reach*, Stone said he was "moved, pleased, and gratified."

"I would like to say how worthwhile this makes me feel to have done a work that called forth such a degree of insight. A response to one's work in terms of insight is the ultimate motive for fiction," he said.

After the readings, the panel questioned the therapeutic virtues of writing and of creativity in general, and addressed the question of distance. How much distance is needed to write something aesthetically meaningful?

Both the writers and the psychoanalysts agreed that telling a story is a way of making sense out of individual and collective experience. They regarded writing and story telling as an attempt to give meaning to suffering and to the experience of life in general. Nevertheless, they could not reach an agreement as to its therapeutic dimension: is the process of writing itself therapeutic or is it merely about making stylistic, purely aesthetic, and quasi-musical decisions?

"Writing is like dreaming," said Denis Johnson, after reading his short story, "Emergency." "Is dreaming therapeutic? Looking back at it helps, but dreaming itself is not therapeutic. The same is true of writing."

One concept the participants all agreed to was the virtue of humor as a means of deflecting some of the impact of a traumatic event and how that helps the writer to acquire necessary distance and to reach a certain amount of "safety" in the process of writing.

It is not clear whether fiction writers are more familiar with the analyst's perception or the patient's. One thing is sure: writers of fiction and analysts share the same task of carefully listening to psyches. ■

Ann Vaessen is a graduate student in journalism at New York University.

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New SAMHSA Director Seeks Unified Message

Charles Curie hopes a special series of sessions at APA's annual meeting next month in Philadelphia will help end a legendary picture of fragmentation and create vision of "one SAMHSA."

BY JIM ROSACK

As administrator of the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Charles Curie, M.A., has his attention pulled in several diverging directions simultaneously every day. His overriding goal, he said in an interview, is to focus that attention into one vision, one mission, to create a more "cohesive voice" to the seemingly fragmented activities of the behemoth government agency.

Presenting a more effective, unified voice for its mission was a primary underlying theme leading to the agency's collaboration on a special series at APA's 2002 annual meeting next month in Philadelphia. The series is titled "Access to Quality Care: What Works?" (*Psychiatric News*, February 15; March 15), and it will run from Monday, May 20, through Thursday, May 23.

Curie said SAMHSA worked with APA to make sure that the series' 29 sessions not only appeal to a wide audience by offering diverse topics and formats—ranging from issue workshops to symposia and lectures—but also reflect the agency's message of complete, integrated care for mental illness and substance abuse disorders.

In an interview with *Psychiatric News*, Curie, a clinical social worker with an extensive background in community and state mental health services, discussed the agency's immediate goals.

"We [at SAMHSA] need to provide a clear and overriding vision of what the public mental health and substance abuse service system should look like," Curie said. "Our goal today is not only to ensure access to treatment and alleviation of symptoms, but also to understand that for people to truly recover, [SAMHSA] also has to be about helping people to find a full and stable life within their community."

Under Curie's direction, SAMHSA's three centers, the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT), are attempting to do just that through a wide variety of programs and services in a $2.96 billion budget for Fiscal 2002.

"Each of the centers within SAMHSA," Curie explained, "has done many good and appropriate things in the field. But as a whole, we've not been able to fully leverage all of those activities because those three centers have not been working in a coordinated way."

Curie stressed he is committed to ending that fragmented approach. Indeed, at times the centers have appeared to be in competition with each other, not only from a budgetary point of view but also from a vision or mission point of view.

"There has been a great deal of discussion around the agency," he said, "about having 'one SAMHSA,' and what we have found is that there really hasn't been a sense of that, either internally or externally."

Since Curie was appointed SAMHSA administrator last November by President George W. Bush, he has taken part in several meetings, all geared to aligning the three centers in a collaborative effort. Activities at each center have been coordinated to send one clear message to the public about what the agency does, and what the administration's policy is with regard to mental health and substance abuse treatment.

SAMHSA has created a formal matrix of priorities, completely aligned with those of the Department of Health and Human Services (HHS). The matrix lists programs and principles that the agency has placed at the top of its priority list as well as cross-cutting principles to be followed in each of the programs.

Charles Curie, M.A.: "We need to ensure that people who need treatment and seek it have access to it."

"Both in substance abuse disorders and with persons who have a mental illness, co-occurring disorders are a significant issue," Curie said, detailing the agency's highest priority. Curie cited studies indicating that anywhere from one-third to two-thirds of patients in the mental health system have co-occurring disorders. "We currently do not have the assessments in place when people come through the door seeking treatment to necessarily ensure that we are getting the full picture of the individual. And even if [the individual is] being appropriately assessed," Curie stressed, "we don't even have the confidence at this point that our systems have the capacity to provide integrated treatment, or even concurrent treatment, to address co-occurring disorders. We are working to address that capacity now."

Other priorities in the matrix include closing the gap between substance abuse treat-

see ***Curie*** *on page 38*

Tchaikovsky Turns Demons Into Works of Beauty

What do the "Nutcracker," "Swan Lake," and other compositions by Tchaikovsky reveal about the composer's mental states? Come to a lecture-recital session at APA's annual meeting to find out.

BY JOAN AREHART-TREICHEL

Do you like listening to music by the great Romantic composer Peter Tchaikovsky? And would you like to learn how his mental states influenced his works?

If the answers are yes, then a forum that will be held at APA's 2002 annual meeting in Philadelphia should be on your priority list.

The forum is called "Music and Mood Disorders: Tchaikovsky" and will be presented by a psychiatrist who is also a highly acclaimed concert pianist—Richard Kogan, M.D., of New York City.

Tchaikovsky suffered from depression throughout most of his life, Kogan explained in an interview with *Psychiatric News*. The depressions started in 1854, when he was 14 years old and when his mother died, and did not let up for the rest of his life.

During his bouts of depression, Tchaikovsky experienced not only pervasive melancholy, but also insomnia, lack of appetite, and other classical signs of depression and sometimes even delusions and hallucinations. Yet while he undoubtedly suffered greatly from these symptoms, they probably also gave him incentives to create his music.

"I think because of the anguish that he experienced, Tchaikovsky was more motivated to create than is somebody who has not experienced such anguish," Kogan asserted. "Many of our greatest creators, not just in music but in other fields, use their inner torment as a source of inspiration."

But Tchaikovsky's depressions were not only a source of inspiration; sometimes he expressed them directly in his music—for example, in the last of his six symphonies. "This is a piece of inconsolable anguish and grief," said Kogan. Nine days after it premiered, Tchaikovsky died, and there is reason to believe that he took his own life.

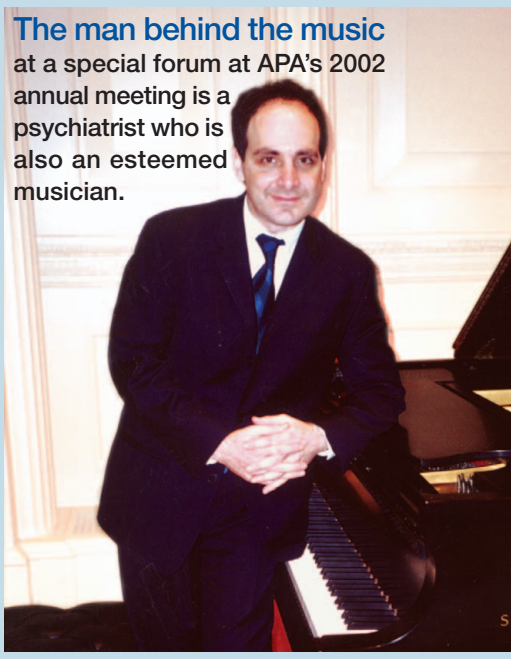
Sometimes Tchaikovsky's depressions prompted him to create fantasy worlds where he could escape—for example, through his ballets. "These were fantasy worlds of beauty, charm, and grace, and they were completely different from his inner melancholy," Kogan explained.

At the annual meeting forum, Kogan will be performing Tchaikovsky's First Piano Concerto as an example of one of the fantasy worlds that Tchaikovsky created. "This is a lavish work with all sorts of gorgeous melodies," Kogan said.

Yet for Tchaikovsky, musical composition was not just an expression of suffering or an escape from suffering, but a lifeline. "He said many times that music kept him sane," Kogan pointed out.

All in all, Tchaikovsky's music is very autobiographical, Kogan said. Thus, those attending Kogan's annual meeting forum will not only learn how Tchaikovsky's mental states influenced his musical compositions, but also will hear, via some of the Tchaikovsky pieces that Kogan will play, Tchaikovsky's poignant life story.

Kogan's forum, "Music and Mood Disorders: Tchaikovsky," will be held Monday, May 20, from noon to 1:30 p.m. in the Pennsylvania Convention Center. ■



The man behind the music at a special forum at APA's 2002 annual meeting is a psychiatrist who is also an esteemed musician.

Who is the man who, at APA's 2002 annual meeting in May, will be discussing Tchaikovsky's mental states and playing some of Tchaikovsky's compositions that reflect those states?

His name is Richard Kogan, M.D., and like Tchaikovsky, he has led a fascinating life.

Kogan's mother, a former music teacher, recognized his music talent and perfect-pitch ability when he was only 4 years old and got him started on piano lessons. He studied piano at the Juilliard School, one of the most prestigious music schools in the world, from age 6 to 18.

But music wasn't the only influence in young Kogan's life. His father was a gastroenterologist and took Kogan with him on medical rounds. Because of this exposure to medicine, and for other reasons, Kogan decided to attend Harvard College rather than a music conservatory, where the focus would have been almost exclusively on music. After that, Kogan decided to go to Harvard Medical School and become a physician.

Yet during his college and medical school years, Kogan also continued to develop as a musician. The dean of Harvard Medical School created a special five-year schedule that allowed him to travel and play concerts between his medical clerkships. He won first prize in a Chopin competition of the Kosciuszko Foundation while he was still a college undergraduate, and then he won the Concert Artists Guild Award and the Portland Symphony National Piano Competition.

Today Kogan is both a psychiatrist and a professional musician. He has a private practice in New York City, serves as director of the Human Sexuality Program at New York Presbyterian-Weill-Cornell Medical Center, and plays piano concerts throughout the world. The *New York Times* has described him as a "superb musician" whose playing is "eloquent and compelling."

Kogan's forthcoming forum on the link between Tchaikovsky's mental states and Tchaikovsky's musical compositions will not be his first one along these lines. At last year's APA annual meeting, for instance, he gave a lecture with performance demonstrations on the mental states and music of the Romantic composer Robert Schumann (*Psychiatric News*, April 20, 2001). And last month, he gave a benefit recital and lecture in New York City's Carnegie Hall on behalf of the National Alliance for Research on Schizophrenia and Depression. The focus was on bipolar disorder and music creativity.

The interplay between mental illness and creativity is a subject of passionate interest to Kogan. "I think there is a profound relationship between mental illness and creativity," he told *Psychiatric News*.

"In psychoanalytic terms, primary processing is nonlinear, nonrational thinking. People who are psychotic engage in primary processing. Secondary processing is what most mentally healthy adults engage in in everyday life. It is more rational, organized thought. Creativity works best when there is a combination of secondary processing and primary processing. The state of creativity might be labeled tertiary processing, where there is a combination."

In other words, he explained, "if an individual is too immersed in a primary-process kind of thinking, he or she may lose a logical structure that is essential for a great work of art. But people who don't have access to those worlds beyond may not be able to create. They are too logical."

annual meeting

Foundation to Sponsor Annual Meeting Events

The American Psychiatric Foundation has planned two events: one will feature Tipper Gore and the other will explain charitable estate planning. Register now for the latter session.

The American Psychiatric Foundation invites annual meeting registrants to attend several special events at next month's annual meeting. They include a session with Tipper Gore and information on charitable estate planning.

The American Psychiatric Foundation will launch its new educational series called "Conversations" with Tipper Gore as the inaugural speaker. This interactive discussion will focus on a wide range of issues important to psychiatry, as well as Gore's own experiences in her battle with depression.

"We are thrilled that Mrs. Gore has accepted our invitation to launch our new Conversations event," said Abram M. Hostetter, M.D., president of the foundation. "Mrs. Gore's unique insights on mental illness will enrich all attendees and compliment the educational and scientific sessions of the annual meeting."

A "Conversation With Tipper Gore" will be held Tuesday, May 21, at 5:30 p.m. at the Park Hyatt Hotel and is open to all annual meeting registrants at no charge. AstraZeneca has provided an unrestricted educational grant to support this program.

On Monday, May 20, the foundation will present an educational workshop by gift-planning expert Richard Barrett, president of Barrett Planned Giving Inc. The session, which will be held at the Park Hyatt Hotel at noon, will provide valuable charitable estate–planning strategies. Participants will learn how to reduce their current, future, and estate taxes and how to provide for a new stream of income now. They will also learn how they can provide support to favorite charities after their death while still ensuring that their heirs are well provided for.

Many people are unfamiliar with planned giving and therefore hesitate to become part of the foundation's program. Barrett will show how a planned gift can maximize the benefits to donors and their families, as well as to their charity of choice. Barrett will also be available at the end of the workshop to answer questions from the audience and to explore specific estate-planning options based on goals and investment portfolio.

Foundation President Hostetter and his wife kicked off the foundation's planned-giving program by establishing a charitable trust to benefit the foundation.

Hostetter said, "I believe strongly in the foundation's ability to make a major impact on psychiatry. Planned giving provided me with the opportunity to support a cause I believe in, and because of the tax and income benefits, I was able to make a larger gift than I had anticipated."

This workshop is free to all annual meeting attendees; however, preregistration is required by contacting Meghan Glynn by phone at (202) 682-6282 or by e-mail at mglynn@psych.org. Box lunches will be provided.

More information about the American Psychiatric Foundation's events and giving opportunities is posted on the foundation's Web site at <www.PsychFoundation.org>. ■

Curie

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ment needs and availability, a priority that also is high on President Bush's list, according to Curie. "We need to ensure that people who need treatment and seek it have access to it," Curie said, noting that the president's budget request for 2003 includes $127 million in new funds to address the issue.

Additional priorities include addressing treatment for mental health and substance abuse in the criminal justice system and the homeless population and a strengthened children's agenda.

"We need to take a comprehensive approach to looking at prevention and early treatment opportunities," Curie added, "which have been understood in a much more concrete way in substance abuse in the past than in a model of mental health wellness."

The series of presentations at APA's annual meeting on which SAMHSA has collaborated will look at many of these priorities, Curie said. It will further the agency's quest to create a working "science-to-services cycle."

"The reports of the surgeon general and from the Institute of Medicine have provided good starting points," Curie noted. "But in keeping with the idea of 'one HHS,' we need to focus on getting what works to the street."

To do so, Curie is working with colleagues at the three related national institutes—Drug Abuse, Mental Health, and Alcoholism and Alcohol Abuse—to clearly define the roles of patients, clinicians, academic institutions, the agency, and institutes to produce a clear cycle of feedback between services that are seen to work, scale of funding and programs at the agency, and corresponding research priorities.

The annual meeting series, Curie said, will help to solidify SAMHSA's role in that cycle and "clarify exactly what each player in the cycle is doing and what the rules are."

More information on SAMHSA is posted on the Web at <www.samhsa.gov>. A list of the annual meeting sessions is posted at <http://pn.psychiatryonline.org/cgi/content/full/37/6/13>. ■

EXHIBITORS' GUIDE

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Philadelphia: Revisiting The City of APA's Birth

BY LUCY OZARIN, M.D.

APA's 2002 annual meeting is being held in Philadelphia, where the organization that became APA was founded in 1844. Surprisingly, in view of its historical connection to this city, this is only the 14th of 155 meetings to be held there. Most fittingly, however, APA has celebrated the important milestones of its 50th, 100th, and 150th birthdays there.

In 1868, when the American Medical Association (founded in 1847) invited the Association of Medical Superintendents of American Institutions for the Insane to merge with it, the invitation was refused on the basis that the superintendents always held their annual meetings in a place that allowed visits to local asylums and where public attention could be drawn to the care of the insane people. Philadelphia met the requirements since the first provision for the insane in the American colonies was furnished by the Pennsylvania Hospital in 1752; the Friends Hospital was established in 1817. These two facilities and the Insane Department of the Alms House (Blockley) were always open to the superintendents during the annual meetings in Philadelphia.

On the evening of October 15, 1844, 12 superintendents met with Dr. Thomas Kirkbride, the superintendent of the Pennsylvania Hospital, at his home on the hospital grounds. The following day the organizational meeting of the association took place at the Jones Hotel at Sixth and Chestnut streets. The objectives of the Association were to allow the superintendents to become acquainted with each other, to further communication about their experiences of caring for the mentally ill, to cooperate in collecting statistical information relating to insanity, and to help each other improve patient treatment, according to Walter Barton, M.D., in his 1987 book titled *The History and Influence of the American Psychiatric Association* (American Psychiatric Press).

The next Philadelphia meeting occurred in 1851 at the hall of the American Philosophical Society. Seventeen members, including five new members, attended. The meetings in 1860, 1867, 1876, 1880, 1884, and 1894 were held at the Continental Hotel and thereafter at the Bellevue Stratford Hotel in 1919, 1932, and 1944. The 115th meeting in1959 took place at the Trade and Convention Center, and in 1994 at the Pennsylvania Convention Center, where much of this year's meeting will be held.

Membership grew steadily for the organization. In 1876, 56 superintendents attended the annual meeting. By 1894, the Association had opened membership to other physicians working with mentally ill people, and 99 members were present, including 49 newly selected physicians. By the 1932 meeting, the Association had 1,375 members; in 1959, that figure was 10,420; and in 2002, approximately 36,000.

Since its beginnings, the annual meetings always included visits to local mental hospitals, places of historic and cultural interest, and social events. At the first meeting in 1844 a visit was made to the Eastern State Penitentiary since members had an interest in the case of "insane" prisoners. Other early meetings included visits to the Girard College for Orphans, the U.S. Mint, and facilities for the blind and deaf. In 1880 Norristown State Hospital and the Women's Medical College extended invitations to the members. In 1884 the state medical society hosted a reception at the Academy of Fine Arts. In 1919 Pennsylvania Hospital gave a luncheon for members, and a visit was scheduled to Valley Forge. In 1932 the Pierre DuPonts provided an evening of entertainment at their Longwood estate, and visits were scheduled to the Veterans Administration Hospital in Coatesville and to the Delaware State Hospital for the Insane in Wilmington.

APA's centennial meeting in 1944 featured an address by Franklin Kirkbride, son of the founder, with a visit to the mansion where the 13 original founders had met on the evening of October 15, 1844. The American College of Physicians arranged an exhibit about psychiatry, joint meetings were held with the American Psychoanalytic Association, scientific and commercial exhibits were held, and motion pictures on psychiatric topics were shown.

At the 1959 meeting the Philadelphia Museum of Art exhibited rare prints of psychiatric interest, reunions of various training programs were held, historic tours of the city and environs were held, and the city government invited members to a cocktail party. The Institute of the Pennsylvania Hospital and Friends Hospital were still on the tour of local sites.

The scope of the annual meeting has expanded beyond anything the founding superintendents could have imagined. This year's meeting will offer 99 symposia, 102 CME courses, 49 industry-sponsored symposia, 24 lectures, and hundreds of workshops, discussion groups, and other sessions. ■

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White Children More Likely To Get Stimulants for ADHD

Of all elementary school children in one community sample, white fourth- and fifth-grade boys with ADHD had the highest rates of stimulant medication treatment.

BY EVE KUPERSANIN

Researchers are hopeful that as they continue to analyze data from a community sample of children with attention-deficit/hyperactivity disorder (ADHD), they will learn more about diagnostic criteria and treatment outcomes.

Researchers at the National Institute of Environmental Health Sciences (NIEHS) and colleagues at the University of North Carolina at Chapel Hill surveyed the parents of all public elementary school children in Johnston County, N.C., from 1997 to 1999.

The NIEHS is a branch of the National Institutes of Health located in Research Triangle Park, N.C., which is close to Johnston County.

More than 80 percent of parents returned the survey; the results appear in the February *American Journal of Public Health*.

The parental surveys revealed that a physician or psychologist had diagnosed 607 of the 6,099 children in the sample, or 10 percent, with ADHD. All of the children in the sample were first- to fifth-graders at one of the 17 public elementary schools in the county.

Of the total sample, 7 percent, or 434, were taking a medication for their ADHD symptoms. Most of the medications—93 percent—were stimulants, and about 10 percent of children taking a stimulant were also taking at least one other medication. The other medications included adrenergic receptor agents such as clonidine or guanfacine, antidepressants, and mood stabilizers.

Principal investigator Andrew Rowland, Ph.D., analyzed the data to explore how treatment with medication differed by the gender, age, and ethnicity of the elementary-school children.

Rowland, who has moved from the NIEHS to the University of New Mexico Health Sciences Center, where he is an assistant professor in the Master of Public Health Program in the school's department of family and community medicine, found that overall, the older white boys in the sample were most likely to receive medication.

The survey did not inquire about information on other forms of treatment for ADHD, such as behavioral therapy.

When Rowland and his colleagues looked at the gender of the children who received treatment, he found that 11 percent of boys in the total sample took stimulant medication for ADHD, while just 3 percent of girls did, a ratio also found in other studies, Rowland noted.

Treatment rates were considerably higher for the older children in the sample. For instance, 62 of the 1,425 children in first grade, or or 4.4 percent, took stimulant medications for ADHD, compared with 87 of the 945 children in fifth grade, or about 9 percent.

The surveys also revealed discrepancies between how often white children received stimulant medication for ADHD compared with minority children. Even though white and African-American children were diagnosed at similar rates, 8.2 percent of the 4,437 white children (364) took medications to relieve symptoms of ADHD, while 5 percent of the 1,208 African-American children (62) did. White boys in the fourth and fifth grades had the highest treatment rates, with more than 15 percent (123 of 800) taking stimulant medication.

According to Rowland, the lower medication-treatment rates for minorities are likely due to the fact that many minorities have poorer access to medical care and less insurance coverage than whites. "There may also be cultural differences in the willingness of some minority families to have a child be treated for behavioral problems with medications," he said.

Rowland and his colleagues suggested that the numbers of children who are diagnosed and treated for ADHD in Johnston County may not be unusual for other counties in North Carolina. "We think that Johnston County is similar to many other counties in North Carolina in terms of the number of physicians per person living in the county, urban and rural characteristics, the distribution of wealth, education levels, and ethnic profiles," said Rowland. "However, similar studies would need to be conducted to know for certain whether these findings could be replicated in other areas of the state."

Rowland said that the strength of the Johnston County study lies in the survey design. "The study provides a good estimate of ADHD medication treatment in one county because parents, as opposed to school officials, are being surveyed about medications taken by children. . . . School-based data are biased toward undercounting the true prevalence of medication treatment," he said.

He explained that school nurses, for instance, when asked whether students are taking medications for ADHD, don't know about, and thus don't report, the use of long-acting stimulants, which some children take at home before they go to school.

The findings from the Johnston County study left researchers thirsting for more in-

see ***ADHD*** *on page 65*

LILY SYMPOS SHELTON
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Researchers Look Beyond Serotonin For Next Antidepressant Advance

Researchers are learning more and more about the complex and often troubling interaction between depression and other illnesses such as diabetes and coronary artery disease.

BY EVE KUPERSANIN

Major depression intensifies the negative consequences of other medical illnesses, according to Dennis Charney, M.D., chief of the National Institute of Mental Health's (NIMH) Mood and Anxiety Disorders Research Program.

"Depression is a systemic disease—it affects the entire body, and that is why it is so serious," Charney told attendees of the National Alliance for Research on Schizophrenia and Depression (NARSAD) "Mind Matters" symposium in New York City in January.

Charney pointed out that depression has long been known to be a risk factor in the development of coronary disease and can even increase the risk of death from a heart attack (*Psychiatric News*, November 16, 2001).

For instance, in a study of 2,847 subjects as part of the Amsterdam Longitudinal Aging Study undertaken by Brenda Penninx, Ph.D., and colleagues, it was found that people with major depression were about four times more likely to die of cardiac disease than people without that diagnosis. The study was published in the March 2001 issue of *Archives of General Psychiatry*.

Dennis Charney, M.D.: "Depression is a systemic disease—it affects the entire body, and that is why it is so serious."

Other studies have found a link between complications stemming from types I and II diabetes and symptoms of depression. "If one gets depressed and has diabetes," said Charney, "it is well known that insulin is not as effective at controlling the disease."

Now there is preliminary evidence that when depressive symptoms lift, glycemic control improves in people with diabetes. Patrick Lustman, Ph.D., a researcher at Washington University in St. Louis, specializes in research on depression and diabetes.

In 1997 Lustman conducted a study of 35 patients with diabetes and depression and 44 with diabetes but not depression. He found that the improvement in depressed patients given nortriptyline was associated with a clinically significant 1.2 percent reduction in glycated hemoglobin—an aggregate measure of blood sugar—over a 120-day period.

Charney also mentioned a study published by Lustman in 2000 that tested a different antidepressant on people with diabetes. "Treatment of diabetic patients with fluoxetine revealed a trend toward better glycemic control."

Researchers have also found that depression may have adverse effects on bone density, according to Charney. For instance, one study conducted in Germany in 1994 by Ulrich Schweiger, M.D., found that bone density at the lumbar spine was 15 percent lower for a sample of 80 people with major depression than in nondepressed control subjects. A follow-up study conducted with the same people four years later found that bone loss over a period of at least two years was 10 percent to 15 percent greater in those with a diagnosis of major depression.

There is also anecdotal evidence showing that depression is associated with a worsening of the condition of patients with cancer, Alzheimer's disease, and Parkinson's disease, according to Charney.

New Treatments on Horizon

Twenty years after the advent of selective serotonin reuptake inhibitors (SSRI), researchers are investigating new classes of antidepressants that would target compounds in the brain other than serotonin for faster and more effective antidepressant effects, according to Charney.

"We don't want to discover 'me too' medications at this point." he said. "Our current treatments are not curative. Although the antidepressants available now are better than placebo, they don't prevent relapse enough."

One such chemical that would be targeted by new medications is corticotropin-releasing hormone (CRH), which is a brain neuropeptide. Researcher Charles Nemeroff, M.D., of Emory University discovered in 1984 that increased levels of the peptide are found in the cerebrospinal fluid of some people with depression, and Charney, along with colleagues at Yale, found increases in CRH in patients with posttraumatic stress disorder in 1997.

Discoveries such as these led companies to develop compounds that would block the function of CRH by antagonizing its binding to its receptor. One such compound developed by Neurocrine Biosciences was licensed to Janssen Pharmaceutica. The compound was found in a German study to decrease symptoms of depression, according to Charney, but was discontinued because it was also associated with an elevation of liver enzymes. However, drug companies such as Bris-

tol-Myers Squibb, Pfizer, and Janssen are developing other CRH antagonists to fight depression.

Charney said that cortisol, a primary corticotropin released when CRH levels increase, has been found to be elevated in people with psychotic depression. He said that "increased cortisol levels may also be related to medical problems such as reduced sensitivity to insulin, osteoporosis, and increased coronary vascular risk."

Research has also found that high levels of the stress hormone may cause a chronic stress reaction that underlies the symptoms of psychotic depression, such as hallucinations, sleep disturbances, and memory problems. However, researchers are unsure of what happens when cortisol levels are abnormally low, as could happen when CRH is blocked. Dosing of CRH antagonists is especially difficult because of the need to bring cortisol levels down to a normal range while not decreasing them below normal.

Two years ago researchers at Stanford University tested the effects of RU-486, or mifepristone, on a sample of 30 patients with psychotic depression. The FDA approved the cortisol-blocking drug in 2000 to function as an emergency contraceptive and, in higher doses, to terminate pregnancy.

Charney said that the investigators found that within just a week, depressive symptoms decreased by 42 percent, and psychotic symptoms decreased by 63 percent in the sample of 30 patients.

"These results are very promising," said Charney, who added that Corcept Therapeutics Inc., a small biotechnology company based in California, is sponsoring a drug trial using mifepristone at 20 sites across the country to further investigate its effect on psychotic depression.

Antidepressants and New Cells

Evidence is now emerging that contradicts what doctors and scientists have been claiming for years—that there is no new cell growth in the adult brain. "We were taught in medical school that, in general, once you were an adult, the brain was fixed," said Charney.

New experiments have shown, however, that if an adult animal is physically active, new cells are created in the animal's brain and that fewer new cells are produced when an animal is under stress.

The most exciting news, however, may be that antidepressant drugs play an important role in cell genesis. "Antidepressants can enhance the creation of new cells in the hippocampus of adult animals," said Charney.

He cited the work of Ronald Duman, Ph.D., a professor of psychiatry at Yale. Duman found that adult rats given fluoxetine had evidence of cell proliferation in the dentate gyrus.

Findings such as this, noted Charney, have "led our field to focus on the effects of stress and depression on brain structure" and whether researchers should develop new compounds that "increase neurogenesis and neuroplasticity in the brain." ■

Scientists Search Genome for Drug-Abuse Link

Some regions of the human genome that contain genes predisposing to drug abuse may have been identified.

BY JOAN AREHART-TREICHEL

The search for genes predisposing to drug abuse may have been narrowed. George Uhl, M.D., Ph.D., of the National Institute on Drug Abuse's Intramural Research Program in Baltimore and colleagues zeroed in on some 1,500 regions of the human genome that are known to vary from person to person. They then examined DNA samples taken from about 700 persons with a history of heavy drug use and from some 300 persons with no significant lifetime use of an addictive substance (controls) to determine what genetic variants they possessed at these particular genetic sites. They then attempted to determine whether the two groups differed significantly in possession of any of the variants.

They did, Uhl and his team reported in the December *American Journal of Human Genetics.* The two groups differed markedly in the possession of some 40 variants.

Thus, some, or perhaps all, of the variants possessed by the heavy drug users may play a role in drug-abuse susceptibility, the researchers believe. In fact, the locations of eight of the 40 variants on the human genome have been previously linked with alcohol or nicotine dependence, bolstering the case that possession of these eight variants at least makes people susceptible to drug abuse.

An abstract of the study, "Polysubstance Abuse-Vulnerability Genes: Genome Scans for Association, Using 1,004 Subjects and 1,494 Single-Nucleotide Polymorphisms," is posted on the Web at <www.journals.uchicago.edu/AJHG/journal/issues/69n6/013154/brief/013154.abstract.html>. ■

AACAP Offers Guidance on Stimulant Drugs in Children

This is the second of two articles on new practice parameters by the American Academy of Child and Adolescent Psychiatry. The first article addressed the use of seclusion and restraint, and this article discusses the use of stimulant medications.

BY CHRISTINE LEHMANN

Are long-acting stimulants as effective as short-acting ones for treating attention-deficit/hyperactivity disorder (ADHD)? What is the maximum daily stimulant dose for a child with ADHD? These and other clinical questions are addressed in a new practice parameter by the American Academy of Child and Adolescent Psychiatry on the use of stimulant medications.

The authors are child and adolescent research psychiatrists Lawrence Greenhill, M.D., of the New York State Psychiatric Institute at Columbia University; Steven Pliszka, M.D., of the University of Texas Health Sciences Center at San Antonio; and Mina Dulcan, M.D., of Northwestern Medical School in Chicago.

They reviewed the vast amount of literature on the clinical use of four stimulants between 1980 and 2000 and drew on their own experience, according to the parameter. The four stimulants are methylphenidate (MPH), dextroamphetamine (DEX), mixed salts amphetamine (AMP), and pemoline (PEM).

Although MPH is the most well-researched and widely prescribed stimulant, the parameter mentions that the four stimulants are equally effective in school-age children, with approximately a 70 percent response rate. However, the use of pemoline is not recommended because research has shown a high rate of liver failure.

The pharmacological effects of the different medications, the disorders and conditions that have responded well to stimulants, and conditions that contraindicate their use are all discussed in the parameter. The criteria for making a diagnosis of ADHD and starting stimulant medications are also described.

Issues such as titration and fixed dosing are discussed, and a helpful table lists initial weekly doses by medication, follow-up needed, and clinical measurements. Another table lists rating scales for assessing ADHD and monitoring effects of stimulant medications.

Long-acting versions of MPH including Ritalin SR20 and newcomer Concerta MPH are discussed in the parameter, as are the pros and cons of short-acting stimulants. Pliszka told *Psychiatric News* that "research on Adderall XR was not available when the guideline was finalized in 2001." The FDA approved the long-acting drug in August 2001 and Concerta in January 2001.

The bulk of clinical trials have been short term, the parameter points out, with the exception of four recent randomized controlled studies that lasted between 12 and 24 months. "Collectively, these long-term studies show a persistence of medication effects over time," according to the parameter.

Greenhill told *Psychiatric News* that more research is needed to study the long-term effects of stimulants on the academic and social skills of children with ADHD.

The parameter indicates that conditions that are comorbid with ADHD, specifically conduct and anxiety disorders, have responded to stimulant medications. Stimulant medications have also been found to improve narcolepsy as well as apathy and depression in medically ill patients, according to the parameter.

Because children as young as age 3 can have symptoms of ADHD, and adults are increasingly being diagnosed with ADHD, the results of the research on these age groups is presented, even though it is limited. Only five controlled studies of stimulants in preschoolers and nine controlled studies of stimulants in adults were published by 1996. In contrast, 157 controlled studies of school-aged children and adolescents were published by 1996, according to the parameter.

The parameter touches on the use of generic versions of brand-name stimulant medications. "Only one study, published in 1998, compared a generic with a brand stimulant. The results showed that the generic version of methylphenidate was absorbed more quickly and peaked sooner than Ritalin," said Greenhill.

Does the use of stimulant medications lead to substance abuse as some critics of these medications have suggested? Two studies are mentioned in the parameter that show that adolescents with ADHD treated with stimulants were less likely to abuse substances than adolescents with ADHD not being treated with stimulant medications.

However, parents and other family members may abuse a child's stimulant medications, states the parameter, so "it is important to ask whether anyone in the house has a problem with substance abuse."

The parameter on the use of stimulant medications was published in the February 2002 supplement of the* Journal of the American Academy of Child and Adolescent Psychiatry.** ***The full version is available to AACAP members free at <http://office.aacap.org/eseries/ScriptContent/Index.cfm>. Ordering information is available at <www.aacap.org/publications/pubcat/guideline.htm> or by phone at (800) 333-7636 ext.131. ■

Gene Discovery Offers Clue To Schizophrenia's Cause

Three genes taken from an area of chromosome 22 are found to be overly expressive in brains of people with schizophrenia, adding to evidence that this particular genetic stretch is involved in schizophrenia.

BY JOAN AREHART-TREICHEL

It is looking more and more as though a stretch of chromosome 22 called the q11-13 region contains genes that are involved in schizophrenia.

For instance, the gene or genes that cause velocardiofacial syndrome come from this region, and about one-third of patients with velocardiofacial syndrome experience schizophrenia-like symptoms. A gene that has been linked with schizophrenia, called the COMT gene, also comes from this region.

And now three more genes that derive from this area have been found to engage in more expression—that is, in more mRNA transcription—if they come from the brains of persons who had schizophrenia than if they come from the brains of persons who had major depression, bipolar disease, or no mental disorder.

The finding comes from Sabine Bahn, M.D., Ph.D., a clinical lecturer in psychiatry at the University of Cambridge in England, and her colleagues and is reported in the April 2 edition of the *Proceedings of the National Academy of Sciences*.

The three genes are called the apolipoprotein L1, L2, and L4 genes. The apolipoprotein L family of genes makes lipoproteins, which in turn play a central role in cholesterol transport. Cholesterol is important in cellular processes during brain development and in the adult brain. The fact that the apolipoprotein L1, L2, and L4 genes are on expression overdrive in brains of people with schizophrenia suggests that they might play a causative role in schizophrenia, Bahn told *Psychiatric News*.

Bahn and her colleagues will now investigate whether apolipoprotein L1, L2, and L4 genes taken from the bloodstream of schizophrenia patients are also overly expressive. "If this is the case," she said, "there could be a possibility of using the genes as a diagnostic tool."

However, she does not foresee that their results will lead to any new ways of treating schizophrenia in the near future. Her suspicion is that the apolipoprotein L1, L2, and L4 genes are only "a first cue hinting at a more complex pathology of specific molecular pathways, like the tip of an iceberg above water."

Bath and her team used high-technology methods called microarrays and differential display techniques to identify the overexpression of the apolipoprotein L1, L2, and L4 genes in schizophrenia.

Karoly Mirnics, M.D., an assistant professor of psychiatry and neurobiology at the University of Pittsburgh, was the first investigator to publish microarray results obtained from brains of people with schizophrenia and controls and is familiar with Bahn's research. "Bahn's findings are very important in the process of uncovering schizophrenia susceptibility genes and processes that may be associated with the symptoms of the disease," Mirnics told *Psychiatric News*.

The research by Bahn and her colleagues was financed by the New Zealand Neurological Foundation, the Health Research Council of New Zealand, the Theodore and Vada Stanley Foundation, and the National Alliance for Research in Schizophrenia and Depression.

An abstract of the article "Gene Expression Analysis in Schizophrenia: Reproducible Upregulation of Several Members of the Apolipoprotein L Family Located in a High Susceptibility Locus for Schizophrenia on Chromosome 22" is posted on the Web at <www.pnas.org/cgi/content/abstract/99/7/4680>. ■

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Partnership Will Reverse Neglect Of Minority Mental Health Issues

Cultural diversity in research is the top priority of an unprecedented five-year partnership between the National Institute of Mental Health and Howard University to study mood and anxiety disorders.

BY EVE KUPERSANIN

For many years, minorities have been conspicuously underrepresented in psychiatric research, both as investigators and subjects. Now, thanks to a $6.5 million grant from the National Institute of Mental Health (NIMH) to Howard University, researchers will gather valuable information on mental health from minority populations.

The five-year grant, awarded in January, will fund a range of studies investigating mood and anxiety disorders and will pay particular attention to cultural and ethnic differences in diagnosis and treatment outcomes.

Researchers at NIMH and Howard University, a historically black, private university in Washington, D.C., will collaborate on the studies. "There has been concern about the lack of research on mental health issues by African-American investigators, as well as a lack of involvement by African-American patients in these studies," said William B. Lawson, M.D., who is professor and chair of Howard University's department of psychiatry.

William B. Lawson, M.D.: "There has been concern about the lack of research on mental health issues by African-American investigators."

"What we at Howard University bring to the table is the ability to look at differences in biological markers for mental illness, as well as the prevalence of symptoms of mental illness across ethnic groups," he told *Psychiatric News*.

Lawson is collaborating with Dennis Charney, M.D., director of the Mood and Anxiety Disorders Research Program in NIMH's Division of Intramural Research Programs, to develop the study protocols to be supported by the new grant.

Charney spoke with *Psychiatric News* about the missions driving the collaboration between NIMH and Howard University. One mission, he said, is to get more minority patients involved in psychiatric research.

"There are critical gaps in information regarding minority patient populations, including response to different kinds of psychiatric medications and differences in etiology or pathophysiology of different disorders," he said. "We are hopeful that we can fill these gaps with this collaborative project."

Charney said that another goal of the multiyear project is to provide mentoring and research training to minority investigators, "so that we can help [the investigators] to be successful in obtaining independent, peer-reviewed funding from extramural sources of grants and, ultimately, attract more minority scientists to the field."

> **"There are critical gaps in information regarding minority patient populations."**

Although the specific research protocols are still in development, Charney said he expects that there will be as many as 10 studies involving both minority and nonminority populations of all ages, and that the studies will most likely begin within the next year.

Charney added that there are some scientific protocols under development at NIMH that may be suitable for participation by Howard University investigators and may benefit from the recruitment of minority subjects.

One of these study protocols would involve adults with depression and diabetes. "Diabetes is a common medical problem in minorities, and there is evidence that patients with depression have reduced sensitivity to insulin," said Charney. "When patients are depressed and they have diabetes, their ability to control glucose is impaired" (see article on page 48).

Charney said that in light of this problem, investigators would like to test the effects of antidepressant drugs on the ability of research subjects with depression and diabetes to control their glucose levels.

Another study may look at the prevention of posttraumatic stress disorder and include subjects who have been exposed to trauma.

Patient populations in all studies will include both minorities, who will be recruited by investigators at Howard University, and nonminorities, who will be recruited at the NIMH Bethesda, Md., campus. All of the studies funded by the grant will take place in tandem at both institutions, said Charney, and investigators at Howard University and NIMH will work together to study treatment outcomes across different ethnic groups. ■

LILLY SYMPOS BAR-
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Nutrient Combo Boosts Memory—At Least in Rats

A combination of two dietary supplements appears to improve memory in old rats. Whether the combination can also do the same for healthy human seniors, or even protect against Alzheimer's disease, however, will become apparent only from clinical trials.

BY JOAN AREHART-TREICHEL

Can a combination of two nutrient supplements counter the benign memory loss that often comes with aging? Possibly, a new rodent study suggests.

The study was conducted by Bruce Ames, Ph.D., a professor of molecular and cell biology at the University of California at Berkeley, and his colleagues and is reported in the February 19 *Proceedings of the National Academy of Sciences.*

The two supplements that were tested are called lipoic acid and acetyl-L-carnitine. Lipoic acid is a potent antioxidant that is able to keep cells from getting damaged by unstable oxygen molecules called free radicals. Lipoic acid can also be found in foods such as spinach, liver, and brewer's yeast. Acetyl-L-carnitine, in contrast, consists of L carnitine (an amino acid involved in fatty-acid transport into cells' mitochondria) plus an acetyl group. Although L-carnitine is amply available in diets containing beef and pork, it is more accessible to both brain and body when an acetyl group is added to it.

Ames and his colleagues used some 300 "old" rats in their experiments, that is, rats a little over two years old. During a seven-week period, some of the rats served as controls, while others received lipoic acid, acetyl-L-carnitine, or a combination of both. All of the rats were then given spatial memory and temporal memory tests. The rats receiving lipoic acid alone or acetyl-L-carnitine alone did a little better on these tests than the control rats did. But the rats receiving lipoic acid plus acetyl-L-carnitine did significantly better on the tests than the controls did.

Ames and his coworkers then examined the hippocampus—that area of the brain that is so crucial to memory—in some animals from the control group and from the treatment groups to see whether they could find any differences between the groups. They could, they found.

Damage Less Pronounced

First, the control animals showed oxidative damage to RNA molecules in cells from their hippocampi—damage that had been brought about by the aging process. However, there was less age-induced oxidative damage to hippocampal-cell RNA molecules from animals that had received either lipoic acid or acetyl-L-carnitine than there was in the control animals. What's more, the damage was even less pronounced in the animals that had gotten the combination of supplements than in the animals that had gotten only one of them.

Second, mitochondria in hippocampal cells from the control animals were deteriorated—a phenomenon that results from the aging process. However, there was less age-provoked deterioration of these mitochondria in animals that had received lipoic acid, acetyl-L-carnitine, or both than there was in the control animals.

"These results," Ames and his team concluded in their study report, "suggest that feeding acetyl-L-carnitine and lipoic acid to old rats improves performance on memory tasks," and that it does so "by lowering oxidative damage and improving mitochondrial function."

"I think it is a great study," Hyla Cass, M.D., a Pacific Palisades, Calif., psychiatrist who has written several books on nutrient supplements, told *Psychiatric News.* The reason, she explained, is because it reinforces some of her own clinical experiences using the two compounds in older patients.

Specifically, she has been advising some of her middle-aged and older patients who have "senior moments" —say, when they forget where they placed their keys—to take acetyl-L-carnitine and lipoic acid, and the patients have reported back to her that the nutrients have helped them.

Applicability to Humans

However, Neal Barnard, M.D., a psychiatrist, nutrition researcher, and president of the Physicians' Committee for Responsible Medicine in Washington, D.C., is not so enthusiastic about the study.

"I find the results very difficult to apply to people for several reasons," he said in an interview with *Psychiatric News.* "First, there are substantial neurological differences between rats and humans. Second, there are also other physiological differences between them, say, in the absorption of drugs. And third, the memory tests used in the study were crude."

If the study's results are found to apply to humans, however, the results lead to a more provocative question: Might acetyl-L-carnitine and lipoic acid be able to counter

see ***Memory*** *on facing page*

Popular Antianxiety Herb Linked to Liver Damage

The FDA is looking into nearly 40 cases of serious adverse events, including some deaths, involving the herb kava, which has been promoted to relieve anxiety, stress, and insomnia.

BY JIM ROSACK

The U.S. Food and Drug Administration is joining authorities in Canada and the European Union in an investigation of the popular herbal supplement kava (also known as kava kava or *Piper methysticum*). The herb is promoted to relieve stress, anxiety, and insomnia, as well as premenstrual symptoms.

European officials have received about 25 reports of moderate-to-severe liver toxicity, and the FDA has logged 38 similar reports, including liver damage severe enough to require transplant and at least one case leading to death.

The Canadian government has urged consumers not to take kava, while sales have been suspended in Switzerland and Great Britain. Germany is moving the herb from over-the-counter availability to requiring a prescription.

In the United States, the National Institutes of Health has suspended two clinical studies of the herb, and the FDA is urging clinicians to look for any connection to the herb in patients with liver failure.

So far, the FDA's inquiry has turned up some startling findings about how Americans use the unregulated supplement. According to FDA officials, many people believe that "as a natural herb, it is perfectly harmless. It is anything but." The agency officials, commenting in a press release announcing the investigation, asked physicians across the country to review files of patients with liver toxicity to determine whether there was any connection with the herb and to question patients who present with new signs of liver failure about use of herbal supplements.

Christine Lewis Taylor, Ph.D., director of the FDA's Office of Nutritional Products, Labeling, and Dietary Supplements, cited the cases of two 13-year-olds who were hospitalized after liver failure suspected of being caused by kava and a women who suffered both kidney and liver failure after taking in excess of 20 kava tablets a day. Another case of severe liver failure involved a woman who took up to 15 kava supplement pills a day, in addition to fluoxetine and other prescription drugs.

In a "dear doctor" letter issued February 12, Taylor urged physicians to report "any cases of hepatic toxicity that you think may be related to the use of kava-containing dietary supplements."

Adverse events should be reported to the FDA's MedWatch program at (800) 332-1088 or on the Web at <www.fda.gov/medwatch>. ■

Memory

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not only benign senior memory problems, but perhaps even protect people from Alzheimer's disease?

This possibility is certainly not lost on Ames and his colleagues. As they concluded in their study report, consuming large amounts of acetyl-L-carnitine and lipoic acid "may be an efficient intervention in humans for delaying brain aging and age-associated neurodegenerative diseases."

How does Barnard regard this notion? "I think there is reason to be optimistic about nutrient use in Alzheimer's disease," he said. However, he stressed, "the studies that are going to nail that down are clinical trials, not rat studies."

So are any trials being done to learn whether a combination of acetyl-L-carnitine and lipoic acid supplements might be able to fend off Alzheimer's?

The answer is yes, Tory Hagen, Ph.D., an assistant professor at Oregon State University's Linus Pauling Institute and one of the scientists involved in this rodent study, told *Psychiatric News*.

He, Ames, and other researchers are giving acetyl-L-carnitine and lipoic acid supplements to men who are over age 65 and have no discernible health problems to establish which doses might confer memory protection and whether such doses might have undesirable side effects. They then plan to conduct a trial to see whether the supplements can retard progression of mild cognitive impairment—a first sign of Alzheimer's—in healthy volunteers.

The rodent study conducted by Ames and his team was supported by grants from the Ellison Foundation, the National Institute on Aging, the Wheeler Fund of the Dean of Biology, and the National Institute of Environmental Health Sciences Center. Their clinical trials are being conducted at Juvenon, a company that Ames and Hagen founded in 1999.

An abstract of the study, "Memory Loss in Old Rats Is Associated With Brain Mitochondrial Decay and RNA/DNA Oxidation: Partial Reversal by Feeding Acetyl-L-carnitine and/or R-alpha-lipoic Acid," is posted on the Web at <www.pnas.org/cgi/content/abstract/99/4/2356?>. ■

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the clinics and hospitals in which they work. This eternal tension between the right of individuals to protect their medical information and the "need" for access of systems so that payment and operations can be maintained continues to seesaw back and forth between Congress and the current administration. When in doubt, we do what is best for the patient; however, our medical colleagues are feeling smothered by regulations and paperwork, and they are therefore less enthusiastic now than before about confidentiality. Maintaining our strong alliances for confidentiality will become only more problematic but absolutely necessary.

During the March meeting of the Board of Trustees in Washington, D.C., the Board granted more than $50,000 in funds to four psychiatric associations to help them address the scope-of-practice issues in their states. In addition, the Board of Trustees voted to approve the recommendation of the Membership Committee to empower the district branches and state associations with the authority to decide whether to offer dues amnesty to former members with the understanding that the national APA would also offer amnesty of APA dues to former members only if the district branches offered amnesty and with the further understanding that the reinstated members would pay dues in advance for the year in which they are being reinstated. This will, it is hoped, clarify the many questions that I receive about former members who would like to again become active.

As I mentioned at the start of this article, I get many requests or questions. They come in three general forms.

- What are the current activities of APA in dealing with this issue?
- Why doesn't somebody at APA do something to ___?
- I am concerned about ___. What can I do to be more effective in my state or with my representatives in Congress in helping them see what is best for our patients?

The third question most recently came from a medical student from UCSF who matched for psychiatry and was concerned that professionals in one state would be placing patients at risk by prescribing medications without a medical degree and without an adequate medical education. He wanted to be sure that New Mexico was an aberration in this country and that it would be considered the high-water mark of such ill-advised legislation. With future psychiatrists thinking and acting as advocates for our patients, we have less to fear about the alleged "domino effect." That theory proved incorrect in Southeast Asia, and we must see to it that the same happens here. We can do that. ■

Whale of a Lesson

I read with interest the article in the February 1 issue regarding research on the mental health needs of astronauts on a Mars mission of two to three years. I was reminded that in the 19th century many men set out in cramped, harsh, dangerous conditions for periods of up to four years on whaling ships. Perhaps our researchers should be reading *Moby-Dick*?

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Wrongful Status

The Department of Veterans Affairs does not give proper recognition to psychiatry as a medical specialty; it is treated merely as a component of the mental health service line. Psychologists, nurses, social workers, and psychiatrists are equally eligible to chair the department.

Psychiatry is being politicized when it needs support as a science. Patients come to VA or private medical centers for serious psychiatric problems needing the service of physicians. VA policymakers are feeding into the antipsychiatry sentiment by making psychiatry an outcast from medicine.

To endorse such a system, there are obviously psychiatrists in the VA hierarchy with identity problems. It filters out prospective newcomers with professional dignity and is humiliating to those who choose a VA career.

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Media Coverage

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nificant crime, most people agreed that Andrea Yates was severely mentally ill," he said. "I think it brought much more awareness of mental illness, with specific reference to postpartum psychosis. From that perspective, psychiatry was enhanced because more people were educated about mental illness."

Nada Stotland, M.D., speaker of the APA Assembly and a former chair of APA's Joint Commission on Public Affairs, said that the generally positive media reporting, as well as the largely sympathetic response of the public, reflects the success of years of public education efforts by APA and other advocates.

"The mainstream media seemed to make a real effort to cover the case fairly," she said. "If anything, I think it showed a considerable amount of understanding about mental illnesses and what they do to people. We have come a long way. People understand that depression is a disease much more than they did some years ago. It shows that continuing our efforts to teach the public is crucial, and it shows that we can actually do it."

Though some media reports have been critical of details of the prosecution's case, Metzner believes that dueling psychiatric opinions were much less of a focus than in the Hinckley trial. At issue in the Yates case, he said, was a straightforward legal one: Did she meet the state's strict M'Naghten definition for insanity?

"In the Hinckley case, people criticized the [veracity] of the diagnosis," he said. "Not here. There was no disagreement that she was significantly mentally ill. The difference among the experts was whether she met the legal standard."

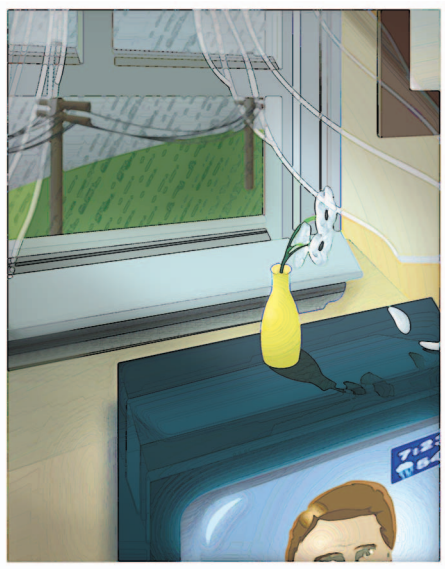
Insanity Defense

While the media publicity surrounding the case was largely positive, the guilty verdict handed down by the jury met with more criticism. And several observers say the case highlights the need for re-examining legal statutes for determining insanity. Yates was convicted in Texas under the so-called M'Naghten standard, a definition of insanity used in 24 other states requiring the defendant to prove that he or she could not determine right from wrong.

"The American Psychiatric Association hopes that the Yates case will lead to broad public discussion of how our society and its legal system deal with defendants who are severely mentally ill," said APA President Richard Harding, M.D., in a statement issued following the verdict. "Historically, the insanity defense was used to excuse from moral culpability mentally ill people who were so deranged that they could not tell right from wrong and could not control their actions. However, reviews of insanity cases show that the more heinous the act, the less likely that an insanity plea will succeed, despite the disabling presence of severe mental illness.

"Also, the standards for handling mentally ill defendants vary across jurisdictions," Harding said. "A mentally ill person tried for a capital offense in one state may be found 'not guilty (meaning not responsible) by reason of insanity,' while another person with similar severity of mental illness tried in another state may be convicted. Advances in neuroscience have dramatically increased our understanding of how brain function is altered by mental illness and how psychotic illness can distort reality in very subtle ways, to the degree that black becomes white.

"Research also has led to development of more effective treatments," Harding said. "Unfortunately, public understanding has not kept pace with these advances."



Justice System Flawed

The National Alliance for the Mentally Ill (NAMI) echoed those comments in a statement issued following the verdict. ". . .[I]f ever there is a case in which mental illness should be seen as a mitigating factor, if not a complete defense, then this is it," said NAMI. "Our shock and disappointment [in the verdict] is tempered by the recognition that the criminal justice system—not just in Texas, but also throughout the nation—is ill suited to addressing issues involving mental illness. The law has not kept pace with modern science. Juries too often are called upon to apply narrow, irrelevant definitions. . . . In Texas, and throughout the nation, NAMI calls for a sweeping re-examination of the legal standard for insanity and how such cases are handled."

Appelbaum said he believes public education is crucial. Regardless of any particular state's definition of insanity, jurors invariably make their judgments on the basis of what they think is right—and invariably their judgments reflect the broader public's understanding of mental illness.

"I know some people are upset at the verdict and thought the defendant's mental disorder was not sufficiently taken into account," Appelbaum said. "But I think the most productive channel for that concern is a focus on using the case to inform people in the general public about the reality of mental disorder, about what it is like to be psychotic, and how people often cannot bear full responsibility for their actions when they are mentally ill." ■

Privacy Rule

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records." Kennedy vowed to hold hearings on the HHS-proposed revisions this month. He also promised to introduce legislation to maintain the stricter privacy protections in the original rule.

Another proposed change to the medical privacy rule would allow parents access to their children's medical records in states where the laws are "silent or unclear. This would allow a health care provider to use discretion to provide or deny a parent access to such records," said Thompson.

Appelbaum said, "APA is concerned about parental access to information regarding psychiatric treatment, reproductive issues, and other sensitive areas of physician-patient interaction. This would give parents who may not place their children's interests above their own interests access to their children's medical records."

APA had praise for another change HHS proposed, however, one that would improve the marketing provision by requiring patient authorization to use and disclose health information for this purpose.

The proposed rule would give health care providers an extra year—until April 2004—to rewrite their contracts with business partners to ensure that patient privacy is protected. Other aspects of the rule have to be complied with by April 2003. However, the AMA and APA objected to the "business associate" provision because it requires health care providers to report or correct patient-privacy violations by their business partners or terminate their contract with them.

The revisions to the rule would not preempt state laws that have stronger patient privacy protections, according to Angela Choi, field director at the Georgetown University Health Privacy Project.

Numerous state laws require patient authorization to disclose personal health information but make exceptions for treatment and payment purposes, according to a report by the Health Privacy Project.

Some states, however, have stronger privacy laws for specific health conditions than what the rule proposes, which would not be preempted, according to Choi.

The rule requires, for example, patient authorization before a physician can release psychotherapy notes to third parties. By contrast, Oklahoma, for example, requires patient authorization before releasing all medical records and communications between a physician or psychotherapist and patient.

Paul Appelbaum, M.D.: "APA strongly objects to the HHS proposal to abandon the fundamental right of patient consent prior to disclosure of personal medical information."

Though modified, HHS kept the "minimum necessary" provision, which requires health care providers, plans, and clearinghouses to "make a reasonable attempt" to limit the amount of individual health information disclosed to other parties "to accomplish the intended purpose."

Another proposal in the rule eliminates the need for researchers to use multiple consent forms. Instead, researchers can use a single combined form to obtain informed consent and to inform subjects of their privacy rights, according to HHS.

Health care providers, plans, and clearinghouses could develop and use a standardized authorization form to obtain a patient's permission for a specific use or disclosure not permitted under the revised privacy rule, according to HHS.

APA is analyzing the proposed revisions and will submit a comment letter to HHS. The proposed rule was published in the March 27 *Federal Register* for a 30-day period in which the public can comment to HHS. This contrasts with the 60-day comment period it usually allows. The agency explained that the shortened period was necessitated by the need to incorporate and publish any regulatory revisions before the privacy rule's previously announced effective date of April 14, 2003.

"APA has long seen confidentiality as the foundation of the therapeutic alliance between patients and their psychiatric physicians."

This is the second comment period HHS has requested on the medical-privacy regulations under the Bush administration. Although the rule was finalized in December 2000 under the Clinton administration, Thompson requested an additional comment period in March 2001, soon after he became HHS secretary.

Information about the Bush administration's proposed changes to the rule on medical-record privacy is posted on the Web at <www.hhs.gov/ocr/hipaa/whatsnew.html>. ■

Children

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nursing facility services, and home-health services.

States can also use the new waiver process to greatly increase the amount of cost sharing imposed on "optional" beneficiaries (those that the state can choose to cover in addition to those the federal government requires it to cover for it to receive federal Medicaid funds). Optional Medicaid beneficiaries, who total 11.7 million people, constitute more than one-quarter of those covered by the program and include 4.2 million children.

"Every dollar counts," said Jay B. Cutler, J.D., director of APA's Division of Government Relations. APA is working with other advocacy organizations to broker an agreement that would allow states to retain unused CHIP money.

The Web site of the National Mental Health Association is <www.nmha.org>; "The New Medicaid and CHIP Waiver Initiatives" is posted at <www.kff.org/content/2002/4028/4028.pdf>; "Blueprint for Change: Research on Child and Adolescent Mental Health" is posted at <www.nimh.nih.gov/child/blueprint.cfm>. ■

FOREST SYMPOS
BLUES
P4C

LILLY SYMPOS KRATOCHVIL

P4C

government news

Women's Health

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on Drug Abuse (NIDA) have a good track record of sponsoring women's health research and gender analysis, said Sherry Marts, Ph.D., scientific director of the Society for Women's Health Research in Washington, D.C.

For example, NIMH-funded studies have "shown that drug treatments produce different responses in men and women with mood disorders," said Marts.

Blehar noted that although women of childbearing age have twice the rate of major depression as men, little is known about the safety and efficacy of different treatments for pregnant or nursing women. NIMH-funded studies are examining how and when mental disorders occur during reproductive transitions and which treatments may be appropriate for women during their reproductive years, said Blehar.

Other NIMH-funded studies are examining the relationship between stress, gender, and mental disorders, said Blehar. For example, understanding of the "fight or flight" response associated with PTSD has been based largely on studies of men. Researchers found that a common female response to stress was "tending and befriending," which may be related to the female hormones oxytocin and estrogen and brain opiates, she said.

Research sponsored by NIDA shows that biological differences between the sexes affect their involvement in drug use, abuse, and dependence. NIDA is also looking at adolescent behaviors that lead to chronic drug abuse in women with the goal of developing prevention strategies. It is also examining drug treatment for women in the criminal justice system, among other areas.

Cora Lee Wetherington, Ph.D., director of the women's health research program at NIDA, said, "We have been sending the message to the field that research on women is an important area to pursue." NIDA has cosponsored conferences on psychosocial issues related to drug use and abuse in women, sponsored travel awards for junior researchers to attend national conferences on drug dependence, and funded research programs to improve the medical treatment of female drug users. "I think researchers are beginning to see the scientific value of recognizing gender differences," said Wetherington.

The 2000 GAO report "Women's Health: NIH Has Increased Its Efforts to Include Women in Research" is posted on the GAO Web site at <www.gao.gov/archive/2000/he00096.pdf>. The NIH Office of Research on Women's Health Web site is <www4.od.nih.gov/orwh/>. The NIMH women's mental health research highlights are posted at <www.nimh.nih.gov/wmhc/highlights.cfm>. NIDA's women's health research advances are posted at <www.nida.nih.gov/WHGD/WHGDHome.html>. The HHS Office of Women' Health Web site is <www.4woman.gov/owh/>. ■

clinical & research news

ADHD

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formation. "There have not been adequate long-term studies on the effectiveness or the safety of ADHD medication treatment using community-based samples," Rowland said, adding that these data should be collected in representative samples of the entire United States population.

Rowland is now analyzing additional data collected in the Johnston County study to determine how many children in Johnston County meet *DSM-IV* criteria for ADHD and how well medication treatment is working for the children in the study.

An abstract of the study, "Prevalence of Medication Treatment for Attention-Deficit/Hyperactivity Disorder Among Elementary School Children in Johnston County, North Carolina," is posted on the Web at <www.ajph.org/cgi/content/abstract/92/2/231>. ■

health care economics

Business

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nostic work-up for the disease. It turned out that he was suffering only from a benign hand tremor.

The program seems to be reaching its goals of promoting cost-effective, quality health care. One in 30 of Honeywell's employees who used the CMR service reported being misdiagnosed, and one in five eventually changed doctors.

The company reported that it earned a $2.80 return for each dollar spent on the service during the first year of operation.

Hines said that the company recently had added attention-deficit/hyperactivity disorder to the list of diseases for which it provides information. CMR typically develops a disease module and tests it with one company before offering it to all its clients.

"One mother who used our service had been so frustrated with the side effects of the medication her son had been receiving that she was about to give up on treatment altogether," he said. But a review of the case revealed that the child had been given an inappropriate dosage for his weight.

The company is considering how best to develop a module for depression. The ability to evaluate treatments is particularly important because of high expenditures on drugs used to treat depression and the impact the illness has on the individual and his or her ability to function at work.

Hines also thinks that involvement of family members will be particularly crucial in considering treatment options and trying to understand the disease. "It will be important for people closest to the individual to become educated about depression," he said.

The Web site for Consumer's Medical Resource is <www.consumersmedical.com>. The Web site for the Washington Business Group on Health is <www.wbgh.com>. ■

JANSSEN RISPERDAL

P4C

JANSSEN RISPERDAL
P4C

AAGP

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Stark gave the keynote address to AAGP's annual meeting last year (*Psychiatric News*, April 20, 2001), and Bartels and Wellstone stood side by side at the press conference announcing the introduction of the Stark-Wellstone legislation to achieve Medicare mental health parity (*Psychiatric News*, May 4, 2001).

When the Office of the Inspector General's (OIG) report said that a significant portion of Medicare mental health expenditures were "medically unnecessary," Bartels refuted that language in an interview with *USA Today*, which resulted in a high-level meeting with the OIG's deputy director and "an agreement to work toward improving the methodology and misleading language contained in the report."

Bartels' third strategic component was strengthening existing and fostering new strategic alliances. He said he is especially proud of "a particularly important new relationship" with the National Alliance for the Mentally Ill (NAMI). AAGP and NAMI will be developing a work group focusing on advocacy efforts for older persons with mental disorders.

Incoming President Kennedy, a professor of psychiatry and behavioral sciences and director of the geriatric psychiatry fellowship training program at Albert Einstein College of Medicine, stated during his inaugural address that he would be focusing on an agenda that was "going to be different, yet complimentary" to that pursued by Bartels. Education, he said, would be the cornerstone of his agenda.

"Our educational approach should honor the whole team, the whole neighborhood of geriatric health services," he emphasized. "And I think we can enlarge our educational perspective without losing our focus as an organization."

Noting that AAGP has a significant number of affiliate members from different disciplines—psychology, pharmacology, nursing, and clinical social work—he invited those members to assume a greater role in teaching alongside geriatric psychiatrists.

"The subtlety that you may not have picked up, though, is that although we are a physician guild, the foundation of our efforts will focus on the whole picture of mental health, not just mental illness," he stated. "Yes, we represent the physician, the psychiatrist in practice, but as you have heard tonight, we—all of us—want to advocate for the interests of the older adult."

Regardless of a health professional's specific discipline or practice, Kennedy said, "if you are working with older adults, you have to be not only competent, but passionate about the care of older persons with dementia and their families."

As part of its educational focus this year, AAGP will hold its first fall institute and, based on APA's successful model, Kennedy said, "take science and evidence-based medicine and teach people how to best apply it in their practices."

Various AAGP committees and the Geriatric Mental Health Foundation will issue evidence-based practice guidelines over the next year, and Kennedy vows to pursue stronger reciprocal affiliations with allied organizations. "We need to be on their program committees, and they need to be on ours," he said. "You cannot lead a team if you don't have a team to lead."

Kennedy dedicated AAGP to honoring what he called the "paradox of independence and security" in old age. "What we want to do for older persons is to support their continuing independence, but in so doing, have them rely on others," he said. "The stakes are high—you and I will only grow old once."

More information on AAGP's activities and annual meeting is available at its Web site <www.aagponline.org>. ■

External Review

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lines for various mental illnesses might not be as "black and white" as those for some other medical conditions, there is ample research to make determinations, particularly in the case of the use of medications, electroconvulsive therapy, and forms of psychotherapy.

She noted the importance of including specialists on review panels, because research about mental illness is proceeding so quickly that only a specialist in a particular disease would be familiar with the latest research. According to the Kaiser study, only Vermont and Minnesota have separate state review panels for mental illness and substance abuse (*Psychiatric News*, March 15).

Kilburn suggested that the small number of cases that reach the level of state external-review panels might in part result from the fact that insurance companies want to settle before the case reaches that point and becomes part of a public record.

The Web site for Hayes Inc. is <www.hayesinc.com>. The Web site for Prest and Associates is <www.prestmds.com>. ■