Volume XXXVIII
Number 12
June 20, 2003

Newspaper of the
American
Psychiatric
Association

PSYCHIATRIC NEWS

Appelbaum Urges Psychiatrists To Be Part of Solution

Association News

Outgoing APA President Paul Appelbaum, M.D., outlines a plan for overhauling this country's woefully inadequate mental health system.

BY CATHERINE F. BROWN

Articles with "see" references appear on pages 7,8,11,13,16,26,30

At the Opening Session of APA's 2003 annual meeting last month in San Francisco, outgoing APA President Paul Appelbaum, M.D., sounded the alarm—as he had done throughout his presidential year—that APA and individual psychiatrists must continue in the quest to end the crisis crippling this country's mental health system.

"The inevitable result of this situation, as I demonstrated for you starkly one year ago, is a critical inability of patients to access needed psychiatric care," said Appelbaum, referring to the speech that he had presented at last year's Opening Session *(Psychiatric News*, June 21, 2002).

Not one to stop at cursing the darkness, Appelbaum told the audience about a major step he had recently taken to address the crisis: the appointment of a task force, led by APA Vice President Steven Sharfstein, M.D., to develop a vision statement for the U.S. mental health system. The statement was approved by the Board of Trustees and disseminated in April.

"Members of the media and government decision makers have already told me how useful they have found this document," said Appelbaum, chair of the psychiatry department at the University of Massachusetts Medical School and director of its law and psychiatry program. "The document creates a set of benchmarks against which progress toward meaningful mental health system reform can be measured."

The document, titled "A Vision for the Mental Health System," is posted on APA's Web site at <www.psych.org/news_stand/visionreport040303.pdf>.

Underpinning the task force's vision, he said, is the following statement: "Every American with significant psychiatric symptoms should have access to an expert evaluation leading to accurate and comprehensive diagnosis that results in an individualized treatment plan that is delivered at the right time and place, in the right amount, and with appropriate supports such as adequate housing, rehabilitation, and case management when needed. Care should be based on continuous healing relationships and engagement with the whole person rather than a narrow, symptom-focused perspective. Timely access to care and continuity of care remain today cornerstones for quality, even as a continuum of services is built that encourages maximum independence and quality of life for psychiatric patients."

Appelbaum shared his own thoughts about the structure of a system capable of achieving these goals.

"For most people with mental disorders," he said to an audience of about 1,500 people in the Moscone Center, "care is best delivered in the context of the general health system."

Many patients, he pointed out, already receive treatment for mental disorders from their primary care physicians. Moreover, demand for mental health services continues to be high, and "meeting this demand requires more access to medical expertise than psychiatrists themselves can provide," he said.

please see ***Appelbaum*** *on page 10*

Paul Appelbaum, M.D.: "Enlightened self-interest alone would suggest that this country should be investing a much greater proportion of its health care dollars in psychiatric care."

How Many Americans Are Uninsured? It Depends On Whom You Ask

Health Care Economics

The uninsured population is constantly changing. Lacking insurance in the short term versus long term represents separate problems that may require distinct policy approaches, health policy experts say.

BY MARK MORAN

Not having health insurance in America is not so much a single problem, as several problems that may be moving targets.

A new report by the Congressional Budget Office (CBO), "How Many People Lack Health Insurance and For How Long?," paints a portrait of the uninsured population as a far more fluid group than is generally acknowledged: a significant number are chronically uninsured, but many are without insurance for a short period only.

And one of the problems of "uninsurance"—a term commonly used to denote not having health insurance—appears to be one with legs: some people are likely to be insured, uninsured, then insured again within the same year. Short- and long-term states of uninsurance are separate problems that may require distinct policy approaches, the CBO report suggests.

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Number 12
June 20, 2003

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Newspaper of the American Psychiatric Association PSYCHIATRIC news

An Equal Opportunity Employer
(ISSN 0033-2704) Printed in United States

Published on the first and third Fridays of each month. Periodicals postage paid at Arlington, VA., and additional offices. Postmaster: send address changes to Psychiatric News, American Psychiatric Association, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209-3901.

Subscriptions
U.S.: individual, $71; student, $25; institution, $125. *Foreign:* international members, $71; nonmembers, $125; institution, $182. *Single issues:* U.S., $11; Canada and foreign: $16; (800) 368-5777.

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Pharmaceutical Advertising: Raymond J. Purkis, Director, APA, 2444 Morris Avenue, Union, N.J. 07083; (908) 964-3100
Nonpharmaceutical Advertising: Brian Skepton, APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209-3901; (888) 35-PSYCH
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Cutler Retires After Decades Of Shaping MH Legislation

Jay B. Cutler, J.D., has retired as head of APA's Division of Government Relations with a 25-year record of impressive legislative accomplishments on behalf of psychiatrists and their patients.

Association News

BY KEN HAUSMAN

As a quarter-century of service as APA's government relations director and chief lobbyist came to a close at the dawn of the new year, Jay B. Cutler, J.D., was able to look back on a legacy of contributions to critical legislation and regulatory changes that improved the lives of people with mental illness.

Honored at APA's recent annual meeting in San Francisco with a Speaker's Award at the Assembly meeting and a Presidential Commendation at the Convocation, as well as at an earlier Capitol Hill reception, Cutler helped shape legislation on almost every issue that touched on the care and treatment of people with mental illness.

Among the most critical of these laws were those concerning insurance parity for psychiatric disorders; patients' rights; children's mental health issues such as portrayals of violence on television; and most recently privacy of electronic medical records, including the successful push to ensure special protections for psychotherapy notes.

He and his staff have also worked successfully to convince Congress to increase budgets for federal agencies such as the National Institute of Mental Health, Substance Abuse and Mental Health Services Administration, National Institutes of Health, and the health care components of the Department of Veterans Affairs.

In the regulatory arena, Cutler was involved in ensuring that the federal government included key mental health care provisions in Medicare and Medicaid rules (including ongoing efforts to have Medicare's discriminatory mental health care copayment abolished). He was instrumental in expanding Medicare's coverage for inpatient psychiatric care and then having all discriminatory limits removed. In 1982 he and his staff worked along with several APA members to convince the Health Care Financing Administration to exempt inpatient psychiatric care from its newly developed payment system based on diagnosis-related groupings.

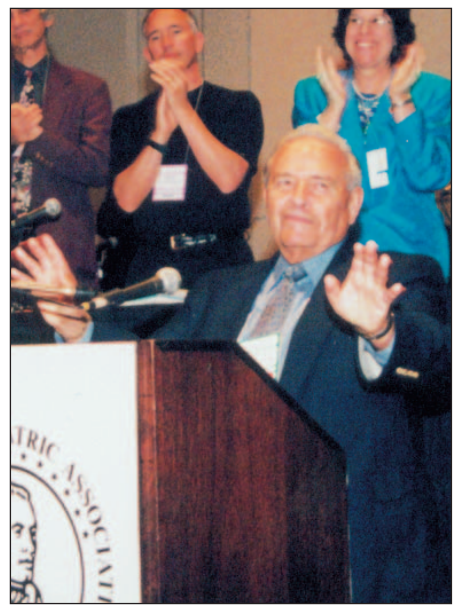
In addition, he led a successful effort to convince the Department of Defense to shut down its controversial experiment to train clinical psychologists to prescribe psychoactive drugs.

His efforts also played a key part in the decisions of the Carter and second Bush administrations to convene presidential commissions on the mental health care system.

Despite this impressive roster of accomplishments, Cutler told *Psychiatric News* that he is most proud of the fact that he knew he had "the absolute trust, confidence, and appreciation" of former APA Medical Director Melvin Sabshin, M.D., with whom he had worked for 20 years. He added that he was also proud that "every Joint Commission on Government Relations' chair and Area leader quickly came to appreciate the political sensitivity, substantive knowledge, and advocacy effectiveness of the Division of Government Relations lobbying team as it carried out APA's mission on behalf of psychiatrists and their patients."

In remarks Sen. Edward Kennedy (D-Mass.) had inserted into the Congressional Record, he stated that Cutler "played an important and unique role in building bridges to increased communication and cooperation across the research, prevention, treatment, and policymaking communities. . . . Say 'Jay Cutler' to literally hundreds of current and former senators, representatives, congressional staff, executive branch officials, consumer advocates, newsmakers, educators, and just plain folks, and you will receive a warm smile of recognition that speaks directly to what made Jay so successful."

Kennedy also acknowledged Cutler's widely admired leadership of APA's lobbying efforts. "To his eternal credit," Kennedy stated, "throughout Jay's tenure as director of government relations, APA could be relied upon to fight just as hard for its patients as its members. This is a model that other trade organizations would do well to follow." ■



Jay B. Cutler, J.D., gets a standing ovation from APA's Assembly in recognition of his years of advocacy work on behalf of mentally ill people and the psychiatric profession.

We've Come a Long Way!

BY MARCIA GOIN, M.D.

I begin this year, assuming the responsibilities of APA president, fortunate to have the organizational stability championed this past year by the leadership of Dr. Paul Appelbaum, supported by the Board of Trustees. We are in a strong position to proceed with our mission: advocating for patients and our profession.

The recent APA annual meeting in San Francisco was remarkably rich with information about the advances and emerging knowledge in neuroscience. Speakers presented fascinating data about neurotransmitters such as GABA and glutamate, mirror neurons, the limbic system, catecholamines, and neurosteroids. We are beginning to understand linkages to clinical practice. One example is a possible neurobiological understanding of the aggressive and fearful reactions of people with borderline personality disorder; reduced activity in the prefrontal cortical control areas may make those parts of the brain less able to modulate the observed overactivity in subcortical areas such as the amygdala and hypothalamus.

The advances in genetics, neuroscience, and developmental psychology are proceeding at an exponential pace! New imaging techniques allow us to observe neurochemical and neurotransmitter interactions and interconnections as never seen before. These developments are so exciting that we must constantly remind ourselves not to lose sight of the whole patient and the complex interactions between nature and nurture.

Why am I dedicating this, my first, presidential column to these issues? I do so because I see this as a pivotal time in the history of psychiatry. We must as a profession ensure that our enlightenment by scientific advances and increasingly effective treatments does not cause us to lose sight of the psychosocial, cultural, and psychological factors whose understanding is critical to the effective delivery of our knowledge.

It is hard to imagine that there was a time when our only available treatments were wet packs, insulin, and ECT. Psychotherapeutic approaches in the past hoped to relieve the symptoms of major mental illnesses through insight and making the unconscious conscious. Battles were waged around the question of whether etiology was biological or psychological. Fortunately, we have come a long way from these destructive encampments. Today we have psychoanalysts including functional MRIs in their outcomes research. It is a rare psychotherapy practice that does not integrate psychopharmacologic treatment. Neurobiologists are attuned to the consequences of stress as it affects the neurosteroids with subsequent impact on neuronal excitability. However, human nature being what it is, there is always a pull toward polarization rather than synchrony.

There is no "either-or" for modern psychiatry. Both nature and nurture are diagnostically and therapeutically relevant. In the 1999 book *The Feeling of What Happens: Body and Emotion in the Making of Consciousness*, Antonio Damasio hypothesizes a process

please see ***From the President*** *on page 26*

APA Links to Research

BY JAMES H. SCULLY JR., M.D.

One of the features that best distinguishes APA as a professional organization is the Association's close affiliation with academic psychiatry and with the broad range of allied organizations that partner in supporting psychiatric research and education. Under the leadership of the APA Council on Research and the Board of Directors of our 501(c)(3) component, the American Psychiatric Institute for Research and Education (APIRE), APA works to ensure that research on the causes, treatment, and prevention of mental disorders continues to be a priority on the national health and human services agenda.

Darrel Regier, M.D., M.P.H., serves as director of the Division of Research under APA and as executive director of APIRE. The APIRE board of 15 members, chaired by Herbert Pardes, M.D., oversees a research and education program funded by federal and private grants of approximately $5 million a year. With this funding, a multidisciplinary and talented APA staff conduct clinical and health services research, foster careers in psychiatric research, and provide the scientific evidence for policy, legislative, and practice initiatives that serve both the patients and the practitioners we represent.

The Division of Research has recently been reorganized to include the Quality Improvement in Psychiatric Services (QIPS) and the Office on HIV/AIDS programs. Hence, in addition to being responsible for maintaining and revising the *Diagnostic and Statistical Manual (DSM)*, the division will be responsible for overseeing production of the practice guidelines and quality-of-care indicators for APA. Publications from these programs generate about $5 million a year (after expenses) through APPI and APA, which together with the $5 million in grants support APA's research and education programs and account for about 19 percent of the total APA income and 14 percent of the expenses. There are 15 staff members in the Division of Research and another 10 supported by APIRE with three part-time consultants; thus, the total staffing is slightly more than 10 percent of the overall APA staff.

In this column I can only briefly sketch the breadth and far-reaching implications of our activities in the research arena. A more detailed enumeration and description—including research fellowship application and contact information—can be found on the APA Web site under the subheading "Research Resources." Likewise, our quarterly newsletter, *Psychiatric Research Report*, provides information about current research opportunities and activities in the field at large. Subscriptions are available free of charge by e-mailing prr@psych.org.

Within APIRE, the Practice Research Network harnesses the voluntary participation of psychiatric practitioners to create a research database on the characteristics of patients, treatments, and professional practice across a full range of treatment settings. The resulting data are used to provide a research base for a wide variety of clinical and policy issues, such as the need for new treatment guidelines, the impact of defunding our public mental health system, and the impact of parity in private health insurance coverage.

A major endeavor undertaken jointly by APIRE and the Council on Research is a long-term development process to produce a synchronous revision of the *DSM* and the *International Classification of Diseases (ICD)*. The objective of this joint project with the World Health Organization is to develop identical diagnostic criteria for use in international clinical practice and research. The first phase of the process was completed in 2002 with the publication of a volume that defines the tasks to be undertaken and the problems to be solved before the actual revision process begins. *A Research Agenda for DSM-V,* edited by David Kupfer, M.D., Michael First, M.D., and Dr. Regier, was designed to facilitate the integration of a rapidly expanding body of scientific information spanning the research spectrum from basic studies to clinical, epidemiological, and cross-cultural research.

Currently, APA is embarking on the next step in the *DSM-ICD* research-planning process. A series of NIH-funded conferences will review the research advances made since the publication of *DSM-IV* in 1994 and identify specific research opportunities to improve the validity of our diagnostic concepts and criteria in up to 10 substantive areas. The international scientific community will then be encouraged to address research gaps to improve our understanding of the etiology, pathophysiology, and variations in the clinical expression of mental disorders in different groups. The results of these combined efforts will ultimately provide the evidence upon which *DSM-V* and *ICD-11* will be based—now scheduled for publication in approximately 2010.

The very foundation, of course, for all the advances in our diagnostic, treatment, and service capabilities lies in the promise held by young physicians who choose research and academic career paths. In the context of a decade-long decline in the numbers of psychiatry residents who elect to remain in academia, APA—along with the National Institutes of Health, Association of American Medical Colleges, Association of Directors of Psychiatric Residency Training, American Association of Chairs of Departments of Psychiatry, Residency Review Committee, and other professional and advocacy groups—is intensely engaged in multiple activities to find solutions that will reverse this deleterious trend.

We invite your participation in all of these efforts, as we at APA headquarters work to foster greater linkages between each of our APA district branches and the national network of academicians and researchers who have become such an important part of the APA membership. In this way, we hope to provide a smooth transition of newly graduating residents into full professional participation and to assure maximum exposure to new research and practice development for all of our members.

I welcome your comments about APA's research work, as well as other matters on your mind. Please contact me by e-mail at medicaldirector@psych.org. ■

On Its Golden Anniversary, Assembly Tackles Diverse Agenda

Among the many issues on the agenda of last month's Assembly meeting was election of new leaders and a debate over whether to alter the formula for determining a district branch's representation.

BY KEN HAUSMAN

In elections held during a three-day meeting in San Francisco in May, members of the APA Assembly elected James Nininger, M.D., the Assembly's recorder, to be their next speaker-elect and Area 1 Deputy Representative Joseph Rubin, M.D., to replace Nininger as recorder.

Nininger, a private-practice psychiatrist in New York City and clinical associate professor at Cornell University Medical College, defeated Jo-Ellyn Ryall, M.D., of St. Louis, who was the Area 4 deputy representative.

The race to succeed Nininger as Assembly recorder saw Rubin, who is in private practice in Portland, Maine, outpoll opponent Louis Moench, M.D., of Salt Lake City, Utah. Moench was the representative for Area 7.

The Assembly speaker does not reveal the vote totals, and ballots are destroyed after the results are announced.

The May meeting marked the 50th anniversary of the Assembly's founding, and perhaps fittingly, the members spent a substantial portion of their time debating the Assembly's appropriate size and representation mix.

The Assembly was presented with a report from an ad hoc task force chaired by former Assembly speaker Al Herzog, M.D., that recommended increasing the number of district branch members that each representative would represent. After heated debate, substantial opposition, and several votes on amended versions, the Assembly decided to send the matter to its Committee on Planning for further review. The task force was appointed by Speaker Al Gaw, M.D., and Speaker-elect Prakash Desai, M.D.

In other actions, the Assembly voted to

• have APA back a policy that encourages the federal government "to oversee the establishment and funding of **universal health care access."** Such a program would have no rules that discriminate against people seeking mental health or substance abuse care. This was the modification of a proposal the Assembly was unwilling to back to have APA go on record endorsing universal, government-sponsored health care insurance.

• call on APA to urge the AMA to "work with all the nation's pharmaceutical firms to [develop] a **single form they would use to determine eligibility for their medication benefit programs."** This is an attempt to reduce the paperwork burden on psychiatrists faced with multiple forms their patients need filled out for these programs.

• **ask APA to establish a task force on universal access** that would advocate for nondiscriminatory universal health insurance for mental health care for all Americans.

• **defeat a proposal to have APA evaluate whether it should continue its membership in the World Psychiatric Association (WPA)**. The proposal maintained that the WPA is a "figurehead organization" that brings little benefit to American psychiatry and took the WPA to task for not investigating charges of misuse of psychiatry in China.

• institute a one-year trial of having **Assembly materials available online and by CD-ROM**. This would replace mailing the group's voluminous reports and background material to Assembly members.

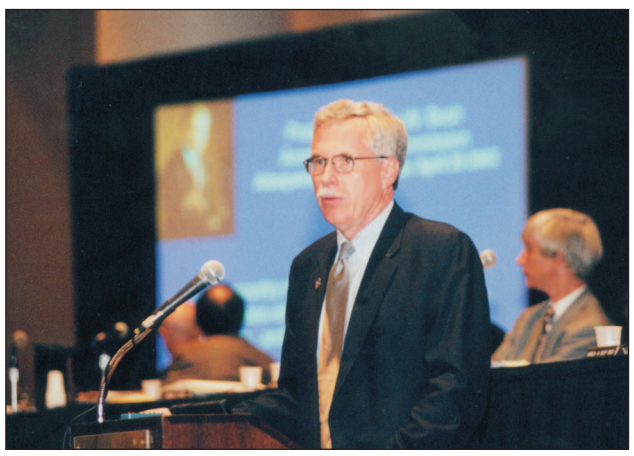
• request that the **Board of Trustees electronically record all its votes**.

• request that APA add a member benefit in the form of **offering free CME**. Members could receive 50 or more Category 1 credits each year.

• **endorse a proposal to have APA "clarify that an evaluation of a capital offender by a psychiatrist expert for mental retardation is not unethical."** The proposal argued that in light of the Supreme Court's ruling banning execution of mentally retarded individuals, a psychiatrist's refusal "to evaluate a capital offender for possible mental retardation, when failure to diagnose may lead to the offender's execution, could be considered unethical."

• **defeat a proposal calling on the AMA to amend an opinion by its Council on Ethical and Judicial Affairs** to add that "on no account should a physician give any opinion that states that a person sentenced to death is mentally competent for execution" or "agree to state, after treatment, that a prisoner is fit for execution."

• urge APA to **adopt a position supporting somatic nuclear cell transfer research,** including its being federally funded, and opposing laws that aim to ban such research.



Michael Hogan, Ph.D., chair of the President's New Freedom Commission on Mental Health, gives APA Assembly members a preview of the commission's soon-to-be-released report.

• Ask APA to institute a **grant program** through which district branches could receive funds to hire public relations consultants who would advise them on developing local public education programs about mental illness and its treatment. The costs of this proposal were estimated to be "high."

• refer to the Committee on Advocacy and Litigation Funding a proposal that APA join other psychiatric organizations, including the American Psychoanalytic Association, in **a lawsuit challenging the legality of the HIPAA regulation** that substitutes "regulatory permission" for a patient's right to consent to the release of his or her electronic medical records. The suit against the U.S. Department of Health and Human Services contends that allowing release of these records to insurance companies and other interested businesses without the patient's express permission is a violation of physician-patient confidentiality.

In addition, the Assembly applauded the presentation of several Speaker's Awards by Gaw. He presented awards to California Assembly member Darrell Steinberg for sponsoring a state law funding mental health services for the homeless (see box); Lydia Lewis, president of the Depression and Bipolar Support Alliance; and former APA Government Relations Director Jay Cutler, J.D. (see page 2).

The Assembly also heard an update on the President's New Freedom Commission on Mental Health from its chair, Michael Hogan, Ph.D. Hogan said he could talk only in generalities because, while the report is complete, it has not yet been made public, so he did not want "to scoop the president."

He did point out that the commission focused on "serious mental illness" and that its goal was not to keep people out of hospitals, but to identify ways to help them "work, learn, and live in the community."

Area 7 Representative Louis Moench, M.D. (left), discusses an action paper with Jeffrey Akaka, M.D., during a break at last month's Assembly meeting. Akaka is the representative of the American Indian, Alaska Native, and Native Hawaiian Psychiatrists.

Among the national goals that he said would be included in the report are establishing an understanding that mental health is essential to health; that to provide "consumer- and family-centered care," health care systems and bureaucracies will have to recognize that they must develop one plan for a person's care; that eliminating race- and place-based disparities in mental health care is "tremendously complicated"; that scientific investigations need to focus on "what's relevant" to clinical care; and that the nation needs to "improve and expand the mental health workforce."

The draft summary of the Assembly's actions will be posted in "Members Corner" section of APA's Web site at <www.psych.org/members/index.cfm> under "Assembly." The Assembly's next meeting will be held November 14 to 16 at the J.W. Marriott in Washington, D.C. ■

ASSEMBLY HONORS STATE LAWMAKER

In 2001, his first year in the California State Assembly, **Darrell Steinberg** managed to engineer passage of a bill allocating $10 million in demonstration grants to programs that serve people who are homeless and severely mentally ill. By his second term, he was able to get the total expanded to $55 million.

For his efforts, APA Assembly Speaker **Al Gaw, M.D.** (left), presented Steinberg with a Speaker's Award at last month's meeting in San Francisco.

Steinberg's legislation targeted people who have suffered from a severe, untreated mental illness for less than one year. He believed that many people in this population who did not "require the full range of services but are at risk of becoming homeless" would benefit from comprehensive individual and family support services to help prevent homelessness and incarceration.

The law funding this project initially covered three counties, but with ample evidence of success, it now provides grants to 38 counties.

Early outcomes data suggest that the benefits Steinberg envisioned did indeed accrue. Program participants had 66 percent fewer inpatient days than matched controls, Gaw noted, and 82 percent fewer days of incarceration.

Steinberg told APA Assembly members that he was "grateful for the opportunity to work to create a genuine mental health system in California."

Goin: APA Will Continue Fight for MH System Reform

Concerned about this country's failing mental health system, incoming APA President Marcia Goin, M.D., urges psychiatrists to become advocates on behalf of their patients and their profession.

BY CATHERINE F. BROWN

Incoming APA President Marcia Goin, M.D., challenged psychiatrists at the Opening Session of APA's 2003 annual meeting in San Francisco last month to become active in advocacy efforts on behalf of people with mental illness to ensure that they have access to the high-quality care they need and deserve.

"We must be front and center in the battle for our patients and our profession or our patients' needs will go unheeded and our profession diminished," declared Goin, director of residency training and the adult psychiatric outpatient department at Los Angeles County General Hospital/University of Southern California School of Medicine.

Much of Goin's speech echoed the remarks of outgoing APA President Paul Appelbaum, M.D. (see page 1), making it clear that she plans to continue the challenging work to which he had devoted much of his presidency and whose goal is a major overhaul of this country's broken mental health system—if it can even be called a "system."

"The American Psychiatric Association must continue to expand its programs to increase public awareness, press for access to care, battle for destigmatization, and assure the recruitment and training of researchers and clinicians to improve patient care and safeguard the future of psychiatry," she said.

Paradoxically, Goin noted, these are both the best and worst of times for psychiatry: These are the best of times because of the galloping pace at which advances in the understanding and treatment of psychiatric illness are being made, but they are also the worst because psychiatry cannot deliver the benefits of science to all those who need it.

"The closing of psychiatric hospitals, the subsequent crowding in psychiatric emergency rooms, and the elimination of community mental health resources speak to the abandonment of our nation's health and social responsibilities," said Goin, who is also a private practitioner. "We must vigorously address the root causes and the consequences of this political folly."

Just some of these consequences are homelessness, disintegration of families, loss of work productivity, increasing numbers of mentally ill people in jails and prisons, and inadequate resources for the juvenile court system and children from disadvantaged backgrounds.

"Untreated psychiatric patients don't disappear," Goin pointed out. "They sit in overburdened emergency rooms, often live on the streets, and ultimately may wind up in jail. Long-range planning imperatives must meet the needs of the psychiatric patient community in these hard economic times."

Marcia Goin, M.D.: "Untreated psychiatric patients don't disappear. They sit in overburdened emergency rooms, often live on the streets, and ultimately may wind up in jail."

She noted that, in addition to state and federal legislators, APA continues to educate decision makers in business and industry about the enormous costs of untreated or poorly treated mental illness. In the United States, $24 billion a year is lost in disability, absenteeism, and decreased productivity. She cited a recent study indicating that 70 percent of 723 employers found that stress or depression had markedly increased as a disability condi-

Old Issues Wanted!

Do you have old copies of the *American Journal of Psychiatry* taking up space in your basement or attic?

If the answer is yes, here's what you can do with them: APA is seeking issues of *AJP* from 1996 all the way back to the year it was founded, 1844. The issues will be used to create a complete online library of the journal that members will be able to access free of charge. Imagine being able to read articles by APA founders and other prominent figures in American psychiatry at the click of a mouse!

To donate back issues, call Sandra Patterson at (703) 907-7894. APA will reimburse donors for postage.

tion—much higher than that of other health problems, such as cancer and heart disease.

While the attainment of true parity for mental health coverage on the federal level is closer than ever, the latest parity legislation before Congress would apply only to employers with 50 or more workers and to health plans in which psychiatric benefits are already offered. "Under such fiscal constraint," Goin observed, "employers may well drop their mental health coverage or circumvent the legislation by requiring higher copayments and deductibles."

To help solve the crisis in mental health care in this country, Goin said that APA must assemble a group of experts "to explore the impact of current policies upon psychiatric care and to construct politically viable recommendations to improve health outcomes for the mentally ill, the disadvantaged, and children and their families."

Turning her attention to other challenges within the profession of psychiatry, Goin referred to the divide that began in the 1960s between the "biological" psychiatrists and the "psychologically committed" psychiatrists. Such polarization, she noted, is unfounded today and contrary to patients' best interests.

"We have gone far beyond the search for the single gene or neurotransmitter to explain psychiatric illness, to an understanding that the biological processes are far more complex and involve both facilitating and protective elements that in turn are highly influenced by environmental and developmental factors. It is folly to separate nature from nurture and see them as independent of one another. In both research and in clinical practice we must strive for an integration of these complex factors that will lead to greater depth in understanding our patients, and therefore to better treatment."

In addition to encouraging and facilitating the integration of the biological and psychological in education, research, and clinical practice, under Goin's leadership APA will continue to influence clinical practice through the development and revision of practice guidelines and continuing medical education.

"Our capacity to do better has never been greater," she told her audience. "This nation has always been a work in progress and it will always be. This national view is mirrored in the values of our APA. We have it in our power to take our organization to new heights of accomplishment. That is our challenge. Your APA is there to meet that challenge, and I am proud to be a part of it. We need your help and involvement in the years ahead, and from the look of the crowds gathered here in San Francisco, I see that we can count on it." ■

Program to Recognize Excellence In MH Services For Minorities

The American Psychiatric Foundation announces the establishment of the Minority Mental Health Awards program.

The program, which is designed to reduce disparities in quality mental health care for minorities, is being supported by a grant from Otsuka America Pharmaceutical Inc.

The American Psychiatric Foundation is a charitable and educational subsidiary of APA. The foundation provides grant support for programs in public education that increase awareness and understanding of mental disorders, advocacy initiatives, and research focused on the treatment and prevention of mental illness.

The Minority Mental Health Awards will recognize psychiatrists, mental health professionals, and mental health programs that have undertaken innovative and supportive efforts to do the following:

- Raise awareness of mental illness in minority communities, the need for early recognition, the availability of treatment and how to access it, and the cultural barriers to treatment.
- Increase access to quality mental health services for minorities.
- Improve the quality of care for minorities, particularly those in the public health system or with severe mental illness.

The foundation will recognize two recipients with an award check in the amount of $5,000. Winning programs will be featured on the Web sites and in the publications of the foundation and APA. Additionally, award winners and their programs will be recognized at APA's annual meetings in May and October.

"Medicaid and other state-funded mental health programs, which serve a disproportionate number of minority individuals, are being cut back drastically by states attempting to balance their budgets," said Abram M. Hostetter, M.D., president of the foundation. "We hope this award program will stimulate psychiatrists and other professionals to find creative ways to provide quality mental health care to these most vulnerable patients."

He continued, "We are thrilled to partner with Otsuka America Pharmaceutical Inc. in establishing this program. The support of Otsuka will make a significant impact in easing the disparities in quality mental health care for minorities."

Hiromi Yoshikawa, chair and CEO of Otsuka America Pharmaceutical Inc., said, "We are delighted to support the American Psychiatric Foundation on a program that will recognize the health care professionals who work to break down the cultural and ethnic barriers to treating mental illness among minorities. The foundation and Otsuka share a common vision to improve the mental well-being of all people."

Applications for the Minority Mental Health Awards must be postmarked by November 1. Winners will be notified in February 2004.

More information can be obtained from the foundation by visiting its Web site at <www.PsychFoundation.org> or calling (703) 907-8517. ■

Outgoing APA President Paul Appelbaum, M.D., presents APA's new president, Marcia Goin, M.D., with one of the tools she'll need to preside over meetings of the Board of Trustees. At left is Appelbaum's daughter, Avigail.

Appelbaum

continued from page 1

Recognizing that primary care physicians may not be up to the task, however, Appelbaum said that they will need additional training and should have access to psychiatric expertise for consultations, preferably on site.

"Collaborative management of psychiatric disorders is the cornerstone of an effective, primary care–based system. Far from excluding psychiatrists from the treatment of most patients, it will tap their knowledge and skills to a much greater extent than is possible today. And no discipline without medical training can possibly substitute for the needed medical expertise," Appelbaum said to loud applause.

For this collaboration to be successful, he continued, changes in reimbursement practices must be made as well. Because psychiatric treatment is often carved out from general care, primary care physicians often cannot get reimbursed for treating psychiatric problems. And most insurers do not pay for consults on patients whom a psychiatrist has not examined directly, he pointed out.

The success of this proposed system also requires that every person have health insurance and that coverage include treatment of psychiatric disorders on a nondiscriminatory basis.

Additional consideration must be made for people with severe and persistent mental illness. "They may require care management, social reintegration, employment training, assistance with housing, and other services that cannot be supplied in a primary care setting. In this extremely vulnerable group of patients, the most logical locus of care is a revitalized community mental health center network," said Appelbaum, again to applause. "This CMHC network should be complemented by an adequate number of beds for acute and longer-term hospitalization."

But how can the American public and political leaders be persuaded to fund such proposals? "Enlightened self-interest alone would suggest that this country should be investing a much greater proportion of its health care dollars in psychiatric care," he said. Currently, mental disorders account for 20 percent of the total burden of disease in the United States, he noted, while only 5.7 percent of all health care expenditures go to the treatment of mental illness.

Apart from the personal suffering such figures imply, there is also another consequence of untreated mental illness that political leaders need to understand: the shifting of costs to other social institutions—such as the correctional, general health care, and social welfare systems—and to the families of people with mental illness, he said.

At the start of his speech, Appelbaum gave APA members reasons to remain hopeful about overcoming the obstacles they and their profession face. He noted that APA continues to campaign for parity and fought to block budget cuts in state and federal budgets for mental health treatment. Moreover, APA helped defeat psychologist prescribing efforts in five states.

Also, he noted, APA created tools to help members remain up to date with scientific and clinical developments, including online CME and a new journal called *Focus: The Journal of Lifelong Learning in Psychiatry*, and posted a variety of tools on APA's Web site to help members comply with HIPAA's medical privacy requirements. Also while Appelbaum was at the helm, APA hired a new medical director—James H. Scully Jr., M.D.

In ending his speech, Appelbaum challenged his listeners to "muster the courage" to follow through on creating a far more effective mental health system for this country.

"When the task seems too difficult, the outcome uncertain, our efforts unappreciated or ignored, we can draw inspiration in this quest from our patients, who often struggle to overcome precisely these feelings as they make their way through life. So I leave you with the words of the Chassidic master Rav Nachman of Bratzlav, who himself suffered from recurrent, intense depressive episodes. Rav Nachman would say to his followers: 'Kol ha'olom kulo, gesher tsar m'od—The world in its entirety is a very narrow bridge; v'haikar lo lefacheid clal—And the most important thing is to have no fear.' "

The document "A Vision for the Mental Health System," is posted on APA's Web site at <www.psych.org/news_stand/visionreport040303.pdf>. ■

Halpern Cited

Abraham Halpern, M.D., is the 2003 winner of the President's Citizenship Award of the Medical Society of the State of New York. Halpern was recognized for his "prolonged and distinguished service to the community in addition but not related to his professional practice." ■

APA Rocks San Francisco

Photo by Ken Hausman

Elvis lives—and in multiples. They were part of the creatively costumed crowd—if costumed at all—participating in an early-morning foot race whose route ran past the Moscone Center.

Photos by Ellen Dalager

The Exhibit Hall was a popular place to visit between scientific sessions.

Convocation lecturer Charles Krauthammer warned of biotechnology's potential to be used in destructive ways but expressed optimism that mankind would make the right moral choices.

A Medem representative explains a new feature of its online services for APA members: consulting and secure e-mail messaging.

Meeting goers take a break from perusing the many booths and exhibits in the Exhibit Hall.

Assembly Recorder James Nininger, M.D. (left), and Speaker Al Gaw, M.D., provide entertainment at a reception marking the Assembly's 50th anniversary.

APA members-in-training flocked to the American Psychiatric Publishing bookstore on Sunday morning, May 18, to take advantage of a 25 percent discount offered exclusively to them.

Meeting goers found plenty of opportunities to learn about the latest research developments in psychiatry. Almost 900 poster sessions were offered at this year's meeting.

Outgoing APA President Paul Appelbaum, M.D., passes the presidential medallion to his successor, Marcia Goin, M.D., at a meeting of APA's Board of Trustees. She assumed the presidency at the close of the annual meeting.

Last month's annual meeting in San Francisco showed that despite an ailing economy and a Code Orange security alert, psychiatrists and others by the thousands (more than 20,000, in fact, breaking previous meetings' attendance records) wanted to be with colleagues in a city known for its numerous cultural attractions, spectacular scenery, and outstanding cuisine.

The meeting inadvertently started off with a San Francisco event whose popularity—and outrageousness—continues to grow each year: the Bay to Breakers Foot Race. On Sunday morning, May 18, many meeting goers riding the shuttle buses had to take an unexpected hike when they discovered that the streets leading to the Moscone Center were closed off to accommodate the race's route. What they saw wasn't the usual collection of sweaty, breathless athletes (see photo top left).

Later that day, the Assembly finished up its semi-annual three-day meeting (see page 7), newly elected officers took their seats on APA's Board of Trustees, and APA's president and president-elect presented alarming messages about the disastrous state of this country's mental health system (see pages 1 and 8). Both Paul Appelbaum, M.D., and Marcia Goin, M.D., urged their fellow psychiatrists to become involved in the quest to secure the funding and services to which mentally ill Americans have a right. Moreover, many members had their first opportunity to meet APA's new medical director, James H. Scully Jr., M.D., who assumed APA's top staff position in January.

Next year's annual meeting will be held in another location popular with many APA members: New York City, from May 1 to 6.

APA, Advocacy Groups Decry MH Budget Cuts

APA's leaders continue their campaign to get the message out that treatment works and cutting funds for mental health services will result in a higher price tag in the future.

BY KATE MULLIGAN

APA Medical Director James H. Scully Jr., M.D., had a question for members of the press at the 2003 annual meeting last month in San Francisco.

He told them, "Our science is better than ever. People can recover. Mental illness is a disorder of the brain. Psychosis is bad for the brain."

Scully then asked, "Why can't we get these messages out?"

The occasion was a press conference that APA sponsored with the National Alliance for the Mentally Ill (NAMI) and the National Mental Health Association (NMHA) to describe the impact of state budget cuts in Medicaid on people with mental illness.

Outgoing APA President Paul Appelbaum, M.D., said that the three associations are united in their concern about the future of the mental health system and intend to be a "formidable force in advocacy."

He told the audience that Medicaid is the source of more than 20 percent of funds spent on all mental health services and provides more than 50 percent of the money directed to the public mental health system.

Every state has cut or plans to cut financial support for Medicaid.

"The hospital emergency room has become the safety net," Appelbaum said.

NAMI President James McNulty told the group that a person suffering an acute psychotic episode often must spend three or four days in a hospital emergency room, waiting for an inpatient bed. "Our members have to deal with the consequences of the crumbling system," he said.

Kenneth Thompson, M.D., a board member of the American Association of Community Psychiatrists (AACP), described problems reported by AACP's members.

"Medicaid is the lifeblood of community programs," he said. "ERs are full. Outpatient is jam-packed. Psychiatrists must see patients faster. Patients arrive in greater distress and suffer more as a result of the cuts."

In response to a reporter's question about competing state and national budget priorities, Scully said, "That's a game politicians play. They say, 'Do you want schools or health care or a bridge?' Don't let them make us choose among them. There is enough money for all."

Appelbaum pointed out that cutting treatment programs does not save money. "People do not stop getting sick," he argued. Instead, costs are shifted from the mental health system to the correctional and social welfare systems.

Incoming APA President Marcia Goin, M.D., told the audience to consider what happened in Los Angeles as a result of decreasing resources for mental health.

A couple of decades ago, Los Angeles County had approximately 2,500 public psychiatric beds, she said. Now, there are 330.

Six years ago, as a result of a grand jury investigation, the county was ordered to improve mental health treatment in its jail or close the facility. The result is a 100-bed psychiatric hospital in the jail. Another 2,300 inmates receive psychotropic medications and evaluations.

"However, it's not cost-effective," Goin said. More important, it's tragic when a person can receive good mental health treatment only in jail and is subject to relapse upon release because of lack of services.

She said that a priority for her presidency will be the collection and dissemination of data that demonstrate the effects of cost-shifting when services are cut.

In May 2003, on behalf of APA's Assembly and Board of Trustees, Herbert Pardes, M.D., a former APA president and former director of the National Institute of Mental Health (NIMH), wrote Thomas Insel, M.D., the current NIMH director, requesting that the institute make mental health economics and service systems research "one of your highest priorities."

Specifically, APA asked for an assessment of the financial, social, and human costs of inadequate mental health treatment on other health, social service, criminal justice, work disability, and educational systems; of cost-shifting between the public and private components of the mental health system, and of the cost-benefit and cost-effectiveness of current and emerging mental health treatments.

Thompson and McNulty echoed Scully's contentions that progress had been made in mental health treatment and that people can recover.

Thompson said, "[Until the cuts] we were on track for improvements in community psychiatry. Our patients were starting to get access to housing. They were being included in planning. We were treating people with dual diagnoses and starting to connect with primary care doctors."

He pointed out that the country was under a Code Orange security alert, creating more stress and greater need for mental health services.

Appelbaum said, "Our security as a people depends on more than inspecting container ships at our ports or making people take their shoes off at airports. It depends on how well we take care of each other."

Reuters News Service, which provides copy to newspapers throughout the country, reported the press conference with the headline, "U.S. Experts Warn of Dangers in Mental Health Cuts." ■

Kenneth Thompson, M.D.: "[Until the cuts] we were on track for improvements in community psychiatry."

Disruptive Physicians Get Makeover In Hospital Therapy Program

Physicians' disruptive behavior negatively affects other medical staff, hospital administrators, and patients. A therapeutic program for doctors and other professionals in Illinois instills respect and accountability.

BY CHRISTINE LEHMANN

A physician worked in a hospital for a decade when a nurse with whom he had clashed threatened to file a lawsuit against him and the hospital. He allegedly waved an instrument in her face and had been verbally abusive for years, according to Glenn Siegel, M.D., a psychiatrist and medical director of Professionals-at-Risk Treatment Services at Elmhurst Memorial Health Care in Elmhurst, Ill.

The doctor targeted in the nurse's lawsuit was shocked when a hospital administrator handed him his personnel file full of complaints from disgruntled nursing staff, said Siegel at APA's 2003 annual meeting last month in San Francisco. He co-chaired a session with program administrator and psychiatric nurse Mary Pittman.

"No one said anything to him for 10 years about his behavior. The administration did not want to antagonize him because he brought in about $2 million in revenue. The nursing staff was told not to deal directly with him. When the vice president of nursing complained to administrators, she was told in essence to 'suck it up,' " said Siegel.

The hospital administrator called the state physician assistance program for advice about how to deal with the disruptive physician and was told that the physician should first be evaluated for his fitness for duty.

"He came here for a two-day intensive assessment. We recommended he enter treatment and gave him several options," said Siegel in an interview.

The physician chose to enter Professionals-at-Risk Treatment Services, where he was required to interact with other patients and staff at least 50 percent of the time and live in an off-campus apartment with other patients. To participate in the program, professionals must make a two- to three-month commitment, said Siegel.

The physician had a strong incentive to follow through; otherwise, the hospital planned to suspend his privileges. A suspension would have meant that his name most likely would be entered into the National Practitioner Data Bank, which is accessible by the public—a step that would have adversely affected his future medical career, said Siegel.

The intensive day-treatment program integrates multiple therapies designed to treat people with personality disorders and mood, anxiety, dissociative, and eating disorders. "We see a lot of people with narcissistic personalities who have issues with entitlement," said Pittman.

Most physicians in the program are men; the ratio of men to women is 9 to 1.

The villain/victim dynamic is common in the relationship between physicians and nurses, said Pittman. As a result of verbal or physical attacks, communicating in an intimidating or demeaning manner, refusing to comply with assignments or participate in committees, and failing to respond to coverage or on-call duties in a timely and respectful way, offending physicians become "villainized" by the nurses, said Siegel. The nurses feel victimized and respond with passive/aggressive behavior, absenteeism, increased staff turnover, low morale, and poor self-esteem and may displace their anger onto patients and families.

These are among the costs to the hospital administration:

- Increased risk of employee lawsuits.
- More time spent counseling disgruntled staff and patients and family members.
- Increased staff turnover.
- More time spent with sexual harassment issues and conflict management.
- Increased expenses spent trying to satisfy the unrealistic demands of the disruptive doctor.
- Time, energy, and money spent in the rehabilitation process.

The costs to the physician are also great. More often than not, the villain/victim dynamic plays out in the physician's marriage, often spilling over into the workplace, Pittman said. Thus, the program requires weekly marital and family therapy.

About half the physicians who enter the program have substance abuse problems. They can be treated in the hospital's inpatient detoxification unit and join patient groups for chemical dependency, said Pittman. Other groups address trauma and abuse and eating disorders.

About 33 physicians are treated annually in the intensive day treatment program, which has operated since 1996. Siegel and Pittman created the program using an inpatient unit in 1990. "With managed care, we later converted that into a partial hospitalization or day-treatment model," said Siegel.

"We believe our program is unique because in addition to offering dual-diagnosis treatment, the staff encourages patients to embrace values that form the foundation of healthy relationships. These values are open, honest, and direct communication, respect for oneself and others, responsibility for one's choices, holding each other accountable, inclusion, and awareness," said Siegel.

"We have seen a remarkable transformation in physicians who use these values. For example, the physician whom the nurse threatened with a lawsuit returned to work where the change in his behavior was noticed by others. The nurse told him, 'Whatever you did worked,' " said Pittman.

The Web site of the Elmhurst intensive treatment program is <www.professionalsatrisk.com>. ■

Psychiatrists Use Intensive Intervention To Prevent Teen Suicides

Researchers in the University of Utah's division of child and adolescent psychiatry have joined forces with the state juvenile justice system and a community parent-training program to help reduce the risk of suicide among troubled youngsters.

BY EVE BENDER

A multiphase study on youth suicide in Utah has led researchers to the juvenile justice system, and ultimately, into homes as they work to prevent suicide in at-risk youth.

The Utah Youth Suicide study began after concerned psychiatrists and mental health professionals in the Salt Lake City area met in the early 1990s to talk about how to end the epidemic of youth suicides in that state, according to principal investigator Douglas Gray, M.D., an assistant professor of psychiatry at the University of Utah in Salt Lake City.

Gray traveled to the annual meeting of the American Association of Suicidology in Santa Fe, N.M., last April to discuss the latest findings from the study.

Rocky Mountain States such as Utah had higher rates of youth suicide than other states in the early to mid-1990s (see map below).

The researchers began their quest to learn about the risk factors for youth suicide by examining government agency data for 151 youth aged 13 to 21 who committed suicide in Utah between 1996 and 1999.

Gradually, Gray and his colleagues pieced together information about the youngsters' lives from statewide databases of the medical examiner's office, department of human services, and juvenile justice system. The researchers also searched computerized school records.

The data from this initial phase of the study appeared in the April 2002 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry*.

Falling Through the Cracks

From the medical examiner's office, Gray learned that 90 percent of the 151 youth who had committed suicide were male, and more than half had used a firearm. Toxicological studies revealed that just 3 percent of the youth had a psychotropic drug in their system at the time of death, yet 24 percent had an illicit drug in their systems when they committed suicide, according to Gray.

Gray and his colleagues were able to obtain school records on 126 of the 151 youth in the sample and found that just 57 percent were enrolled in or had graduated from a school at the time of their death.

Gray explained that some of the youngsters had moved from place to place with their families and had not registered with the school district in their new location.

Douglas Gray, M.D.: "We're giving the kids and parents what they need to succeed."

The researchers also discovered that 63 percent of the 151 youngsters who committed suicide had had previous contact with the juvenile justice system. Of the 95 youth with a juvenile justice record, more than half were charged with truancy or possession of marijuana or alcohol. Aggressive behavior landed a third of the 95 youth in the juvenile justice system, Gray said.

When Gray compared the juvenile justice contacts of the suicide completers with those of all Utah youth of the same age and gender, he found an association between contact with the juvenile justice system and suicide. "We found that the more offenses a youth commits, the greater the risk of suicide," he said.

Gray characterized the suicide completers with juvenile justice contact as living at home with their parents and committing a number of minor offenses over a period of several years—a time lag that allows for identification and treatment of at-risk youth, Gray pointed out.

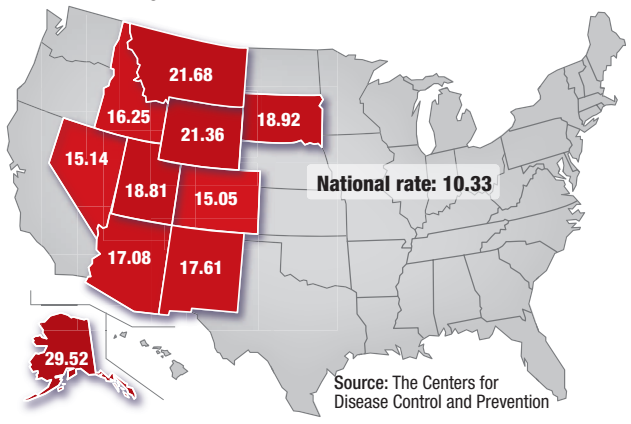
Barriers to Treatment

But before they could intervene, the researchers wanted to learn more about the suicide completers. So they went to the people who knew them best—their parents, siblings, and friends. In parent interviews, the researchers learned that 65 percent of the parents identified their son or daughter

please see ***Suicide*** *on page 31*

Youth Suicide Rates Highest In the West

The 10 states with the highest occurrence of suicide cluster in the West. Figures are for rates per 100,000 youths aged 15 to 19 from 1992 through 1997.



Source: The Centers for Disease Control and Prevention

False Sex Abuse Accusations Lead to Revision of Theories

Research in the last decade indicates that most interview techniques and assumptions used in alleged child sexual abuse cases are seriously flawed. Thus, psychiatrists should be sure to read the latest literature before they testify in such cases.

BY CHRISTINE LEHMANN

Psychiatrists who testify as experts in alleged child sexual abuse cases may undermine their credibility if they rely on outdated research and techniques, said forensic child and adolescent psychiatrist Diane Schetky, M.D., at APA's 2003 annual meeting in San Francisco last month.

"I am amazed at experts who, despite the lack of evidence, continue to rely on a child's behavior as an indicator of sex abuse," said Schetky, who has served as an expert witness in numerous cases of alleged child sexual abuse in the last 25 years.

Research has shown that sexualized behavior, for example, can be attributed to a number of other causes, including family sexuality, violence, and hours spent in day care, according to Schetky. Investigators have widely used children's drawings, diagrams, and anatomically correct dolls to yield information that might support allegations of child sexual abuse.

However, studies have shown that young children may not appreciate the symbolic value of diagrams, adult questioning may influence the content of drawings, and dolls may increase recall but lead to inaccurate reports, said Schetky.

The research was driven primarily by sensational cases of alleged child sexual abuse in day-care centers in the 1980s, said Schetky.

"The public was outraged about the way the investigations were conducted and the ensuing miscarriages of justice that put innocent people in prison," said Schetky.

The research showed that between 23 percent and 33 percent of child sexual abuse cases involved false allegations, between 2 percent and 8 percent of cases involved deliberate lies by children, and the majority of reported cases were unfounded, said Schetky.

Several forces collided to create this phenomenon, including very young witnesses, inexperienced experts, poorly trained investigators, and role confusion.

"Interviewers were gullible, asked leading questions, conducted multiple interviews that led to delayed disclosures with fantastical details, and failed to consider other explanations for the children's behaviors," said Schetky.

Therapists confused the absence of memory with repression of a traumatic memory, believed that memories were immutable and could be recalled from birth, and assumed a person who felt abused had indeed been abused, said Schetky.

Despite the lack of empirical evidence, therapists embraced and testified about various syndromes in court to explain the dynamics of sexual abuse. These included the sexual accommodation syndrome, a theoretical model designed to explain the dynamics of an incestuous family, and the sexually abused child syndrome, said Schetky.

Researchers found that children aged 11 and older were less suggestible than younger children, and preschool children were highly suggestible, said Schetky.

"The most reliable interviewer technique to obtain a narrative history from children was using open-ended questions and the child's own words," said Schetky.

Some studies suggested that the first interview with the child is the most accurate, said Schetky.

During the last decade, psychiatrists conducted research on the long-term consequences of child sexual abuse. However, the results have been inconclusive. For example, a large retrospective study of women who were sexually abused in childhood showed a correlation with all psychiatric disorders, but another study on the effects of childhood sexual abuse showed a specific correlation with depression, suicide outcome, and posttraumatic stress disorder, according to Schetky.

The mixed results make predicting long-term outcomes of childhood sexual abuse risky, she concluded.

Judges in federal courts are largely responsible for determining the admissibility of testimony. "The impact of the Supreme Court's decision in 1993 in *Daubert v. Dow* was to increase judges' awareness of scientific methods and concepts of reliability and relevance. The plaintiff (Daubert) lost the case because of conflicting expert testimony from physicians and researchers. The ruling led to the publication of the *Judge's Scientific Reference Manual* in 1994," said Schetky.

The impact of the ruling has been increased scrutiny of expert testimony, particularly in civil cases. "I recently spent a day answering questions from the opposing attorney about the methods and research I used in reaching my opinions," said Schetky.

"Ethical Guidelines for the Practice of Forensic Psychiatry" is posted on the Web site of the American Academy of Psychiatry and the Law at <www.aapl.org/publ.htm>. ■

Forensic child and adolescent psychiatrists Diane Schetky, M.D. (left), and Elissa Benedek, M.D., receive the Manfred S. Guttmacher Award from Michael A. Norko, M.D., chair of the award committee. They were honored for their book *Principles and Practice of Child and Adolescent Forensic Psychiatry,* published last year by American Psychiatric Publishing Inc.

Maine to Work With HHS After Court Allows Medicaid Drug Plan to Operate

The U.S. Supreme Court lifts the prohibition on Maine's plan to use the threat of prior authorization to extract rebates from drug companies, but the battle is not over.

BY KATE MULLIGAN

On May 19 the U.S. Supreme Court issued a 6-3 decision that lifted an injunction preventing the Maine Rx program from being implemented.

Gov. John E. Baldacci (D) convened a work group of legislators and health advocates who helped design the original drug program to examine the decision and revise the program if necessary. On May 29 he presented a revised prescription drug program, Maine Rx Plus, to the legislature.

Maine Rx Plus calls for the establishment of a preferred drug list for participants in MaineCare (the state's Medicaid program). Residents eligible for Maine Rx Plus will be able to buy the drugs on the MaineCare preferred drug list at Medicaid prices, which are discounted.

The new program specifies that eligibility for Maine Rx Plus is limited to those whose income is at 350 percent of the federal poverty level or lower. The income limit for a family of four will be approximately $64,400. Maine Rx did not have an income restriction.

In the Supreme Court decision, Justices Stephen G. Breyer and John Paul Stevens noted that the secretary of Health and Human Services (HHS) has the legal right to review Maine Rx because the program could be viewed as an amendment to the state's Medicaid plan, which requires HHS approval for implementation.

In an opinion joined by Justice David Souter, Justice Ruth Ginsburg, and Breyer, Stevens wrote, "[W]e offer no view as to whether it would be appropriate for the Secretary to disapprove this program if Maine had asked the Secretary to review it. We also offer no view as to whether it would be proper for the Secretary to disallow funding for the Maine Medicaid program if Maine fails to seek approval from the Secretary of its Maine Rx Program."

A spokesperson for Maine's Department of Human Services told *Psychiatric News* that state officials planned to work with HHS to find "common ground" concerning the program.

The court rejected the argument of the Pharmaceutical Research and Manufacturers of America (PhRMA) that the plan discriminates against interstate commerce in order to subsidize in-state retail sales. Stevens wrote, "Maine Rx does not regulate the price of any out-of-state transaction by its express terms or its inevitable effect. Nor does Maine Rx impose a disparate burden on out-of-state competitors."

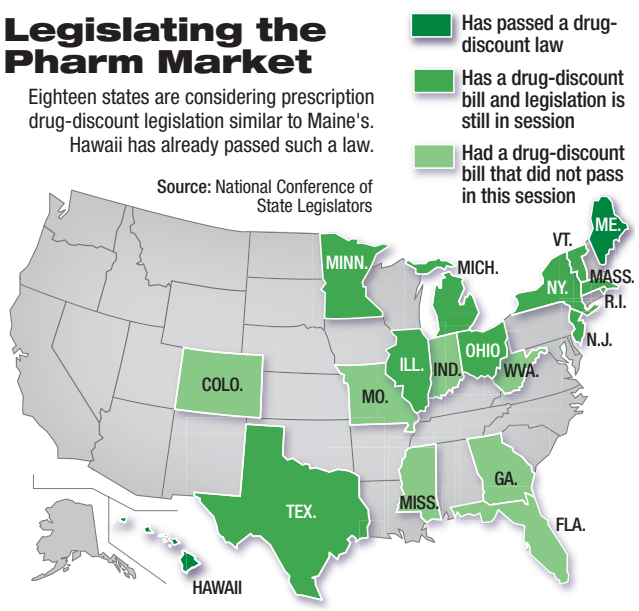
Stevens, joined by Souter and Ginsburg, ruled against the argument that the program violated federal law because it might interfere with Medicaid benefits without serving any Medicaid purpose.

He wrote that the program might serve the Medicaid-related purposes of providing benefits to "needy people" and curtailing the state's Medicaid costs. With access to less-expensive drugs, people with low incomes might not end up on the Medicaid rolls.

Stevens wrote, "The Medicaid Act gives states substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage as long as care and services are provided in the recipients' best interests."

Maine's legislature enacted the program in 2000. In October of that year, PhRMA successfully challenged the program in the U.S. District Court for Maine based on constitutional grounds, including violations of the interstate commerce clause *(Psychi-*

please see ***Maine*** *on page 30*



VA Mental Health Programs Get Good Grades–And Bad

The first VA Summit at APA's annual meeting in San Francisco showcased the department's "world class" research and focused on problems in providing access to care.

BY KATE MULLIGAN

Outgoing Speaker of the Assembly Albert Gaw, M.D., convened the first-ever VA Summit at APA's 2003 annual meeting last month.

The event turned into a showcase of the accomplishments and problems of the Department of Veterans Affairs (VA) mental health services program.

Among those accomplishments is a *New York Times* (May 20) citation for research presented at the summit by Robert Rosenheck, M.D., about the cost-effectiveness of olanzapine.

Rosenheck, who is director of the Department of Veterans Affairs Northeast Program Evaluation Center, reported the results of the largest independent study comparing olanzapine and haloperidol. The study found no advantages for the use of olanzapine over haloperidol in terms of symptoms, Parkinsonian side effects, or quality of life.

Olanzapine was, however, associated with less akathisia and better cognitive functioning than haloperidol.

Total VA costs for olanzapine per patient per year were $3,000 to $9,000 greater than those for haloperidol.

Olanzapine's manufacturer Eli Lilly funded the study, but it was conducted under the auspices of the VA's cooperative studies program.

Noting that these findings differed in important respects from those of studies conducted by the manufacturer, Rosenheck said, "This study is a good example of the VA's service to the public by conducting independent assessments of commercial products."

(The study will be reported in full in the next issue of *Psychiatric News*.)

The VA's deputy undersecretary for health policy coordination, Frances Murphy, M.D., told the group, "The VA is not only delivering excellent health care, but [the department] is getting recognized for it. We are doing a better job of measuring the results of what we do."

She said that the next challenge for the department is to ensure continuity of care.

APA President Paul Appelbaum, M.D., said that the VA's research on PTSD is both critically important and "world class."

He added that the VA's mental health services are more important than ever because resources for mental health are decreasing outside the VA.

Appelbaum expressed concern about waiting lists, demoralization of the VA staff, and the impact on academic departments of psychiatry of inadequate resources for mental health within the VA.

When Gaw opened the meeting for comments, Joel Kutnick, M.D., said, "We have terrible, terrible problems at Corpus Christi. We have 2,000 patients on a panel for one psychiatrist. We don't even have a clerk to do administrative work. Veterans are not getting good mental health services, although the mental health team is doing the best job they can under the circumstances."

Kutnick is a staff psychiatrist at VISN (Veterans Integrated Service Network) 17.

Incoming APA Area 4 Trustee Sidney Weissman, M.D., echoed Appelbaum's concern about the impact of declining resources for the public mental health system.

"We must focus on heightened effectiveness. As states implode, there will be a greater drain on the VA's mental health services," he said.

Weissman is a program and system analyst at VISN 12 and a professor and director of psychiatric training at Northwestern University in Chicago.

Incoming Assembly Speaker Prakash Desai, M.D., said the Assembly had produced a "major document" with recommendations about treatment of the people with serious and persistent mental illness (SPMI).

"The VA and public mental health systems both carry a large burden for the care of patients with SPMI," he said. "The Assembly's work demonstrates an increased focus in APA on issues that are important to the entire public sector, as well as the VA."

Desai is chief of staff at the West Side Division of the VA Chicago Healthcare System.

A psychiatrist commented that only 25 percent of the psychiatrists within the VA are members of APA. He contended that the VA inadvertently contributes to this low figure because it reimburses nonmembers $700 for attending the annual meeting and reimburses members $200, thus undercutting the advantage of the member meeting discount.

In concluding remarks, Rosenheck said, "It's amazing what's happened at the VA. We see twice as many patients as we did in 1995. The pain that's been expressed here is totally valid. But, what gets done is totally remarkable." ■

New International Group Links Young Psychiatrists

A new association has been formed to bring young psychiatrists throughout the world together. It already has some 150 members from countries as diverse as Japan, Nepal, Nigeria, Romania, Syria, and the United States.

BY JOAN AREHART-TREICHEL

More and more psychiatrists throughout the world are interacting with each other, regardless of whether they are clinicians or scientists (see story on page 17). But perhaps no better an example of the growing global psychiatric exchange can be found than a newly formed organization called the World Association of Young Psychiatrists and Trainees (WAYPT).

The association was officially inaugurated in San Francisco last month, prior to APA's 2003 annual meeting.

The purpose: to bring young psychiatrists and psychiatry residents from various countries into contact with each other, both via the Internet and in person; to share ideas and interests; to reduce the isolation of colleagues, especially those in countries with limited resources or few psychiatrists; and to think and act within an international perspective as the world becomes more interconnected. The association also plans to organize a broad range of educational and training programs for its members.

Present for the inauguration of WAYPT were these young psychiatrists: Julian Beezhold, M.D., of Addenbrooke's Hospital in Cambridge, England; Victor Buwalda, M.D., of the Free University of Amsterdam, the Netherlands; Fumiko Maeda, M.D., of Japan and currently a psychiatric researcher at Stanford University in San Francisco; Adriana Mihai, M.D., of the University of Medicine in Mures, Romania; Daniel Müller, M.D., of the University of Toronto in Canada; Christopher Andrew Ramsey, M.D., of Columbia University in New York City; Tanja Suomela, M.D., of the University of Turku in Finland; and Kai Treichel, M.D., of the Medical and Social Center in Angermünde (Berlin), Germany.

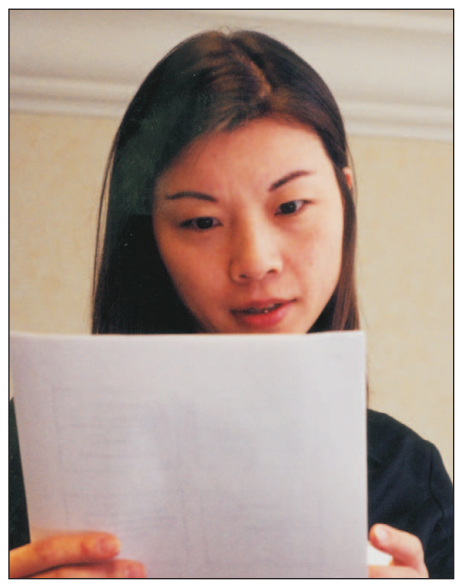
While only this small group of psychiatrists was present for the official launching of WAYPT, more than 150 young psychiatrists and psychiatry residents from 70 countries have joined the association. The countries include Bhutan, Brazil, Costa Rica, India, Indonesia, Iran, Nepal, Nigeria, and Syria.

The groundwork for WAYPT was laid a decade ago when some young psychiatry residents in Europe organized the European Federation for Psychiatric Trainees (EFPT). The purpose of EFPT was to bring psychiatry residents from various European countries together to exchange ideas and to participate in exchange programs. By 1995, psychiatry residents from 14 countries had joined, and by 1999, EFPT had obtained a permanent seat on the European Board of Psychiatry with residents from 18 countries as members.

Things were going so well with EFPT, in fact, that two of its members—Buwalda and Treichel—thought that perhaps the time had come to establish a world organization for psychiatry residents. After all, they reasoned, the world was becoming smaller, and the Internet was making international contact easy. Then in 2000, at APA's annual meeting in Chicago, Buwalda had the good fortune of attending a workshop with Michelle Riba, M.D. (APA's incoming president-elect) and Fritz Hohagen, M.D., a psychiatrist from Lübeck, Germany, who was active in the World Psychiatric Association (WPA). Both Riba and Hohagen endorsed the concept of a world association for psychiatry residents. By the end of 2000, the small band of "young turks" listed above had met in Berlin and decided to form such an organization.

The group met again in 2001 and 2002 during APA's annual meetings in, respectively, New Orleans and Philadelphia, as well as in Japan during the World Psychiatric Congress in 2002. In the course of these meetings, the group decided to include early career psychiatrists in addition to psychiatry residents in the new association because it was felt that, for continuity reasons, it would be a waste of experience

please see ***New Group*** *on facing page*



Fumiko Maeda, M.D., of Japan (left) and Tanja Suomela, M.D., of Finland are two of the founding members of the World Association of Young Psychiatrists and Trainees.

Meeting Proves Psychiatry Has No Borders

This year's APA annual meeting brought leaders of some of the world's prominent psychiatric organizations together to discuss their organizations' activities.

BY JOAN AREHART-TREICHEL

The world is growing smaller as far as psychiatry is concerned. This trend is probably not surprising, considering the ease of 21st-century air travel and communication through the Internet.

A prime example was found in a workshop held at APA's 2003 annual meeting in San Francisco last month titled "International Psychiatric/Psychopharmacological Organizations' Collaboration."

Leaders of some of the world's most prominent psychiatric organizations came together to describe their organizations' activities and to discuss possible collaboration. The leaders included outgoing APA President Paul Appelbaum, M.D.; incoming APA President Marcia Goin, M.D.; Herbert Meltzer, M.D., president of the Collegium of Internationale Neuropsychopharmacologium; Yves LeCrubier, M.D., president of the European College of Neuropsychopharmacology; Carlos Hojaij, M.D., president of the World Federation of Biological Psychiatry; and John Cox, M.D., secretary general of the World Psychiatric Association.

What's more, such organizations themselves are involving an increasing number of the world's psychiatrists and psychiatric investigators.

For instance, about a third of the psychiatrists who attended this year's annual meeting in San Francisco—some 6,000 psychiatrists—hailed from countries other than the United States, Appelbaum reported. The *Diagnostic and Statistical Manual of Mental Disorders* has become something of a world standard for psychiatric diagnoses, he said, and APA is the largest publisher of psychiatric books in the world.

Although the European College of Neuropsychopharmacology has only about 700 members, some 5,000 neuropsychopharmacologic researchers attended its last conference, LeCrubier said. What's more, the college holds workshops, where it particularly tries to further the efforts of young scientists.

Before he was secretary general of the World Psychiatric Association, Cox was president of the Royal College of Psychiatrists in the United Kingdom. That organization is also becoming more international, Cox said; it has some 11,000 international members.

Finally, these organizations are attempting to bring more and more psychiatrists and psychiatric researchers from various countries into their fold or at least to reach more and more of them.

For example, the Collegium of Internationale Neuropsychopharmacologium, which currently has some 900 members, is trying to recruit more from developing countries. It also holds regional conferences, for example, in South Africa or the Middle East, that are convenient for neuropsychopharmacologic scientists in those areas to attend.

The World Psychiatric Association, Cox explained, is likewise encouraging the involvement of more psychiatrists throughout the world—not just via congresses, education, research, and scrutiny of psychiatric abuse in various world regions, but via a new journal, *World Psychiatry*. ■

New Group

continued from facing page

to cut off the early career psychiatrists after they finished their residency, and because early career psychiatrists nowadays share problems similar to those of residents in a rapidly changing health care environment. Last month the group once again came together in San Francisco to launch officially an organization for both early career psychiatrists and psychiatry residents—the WAYPT.

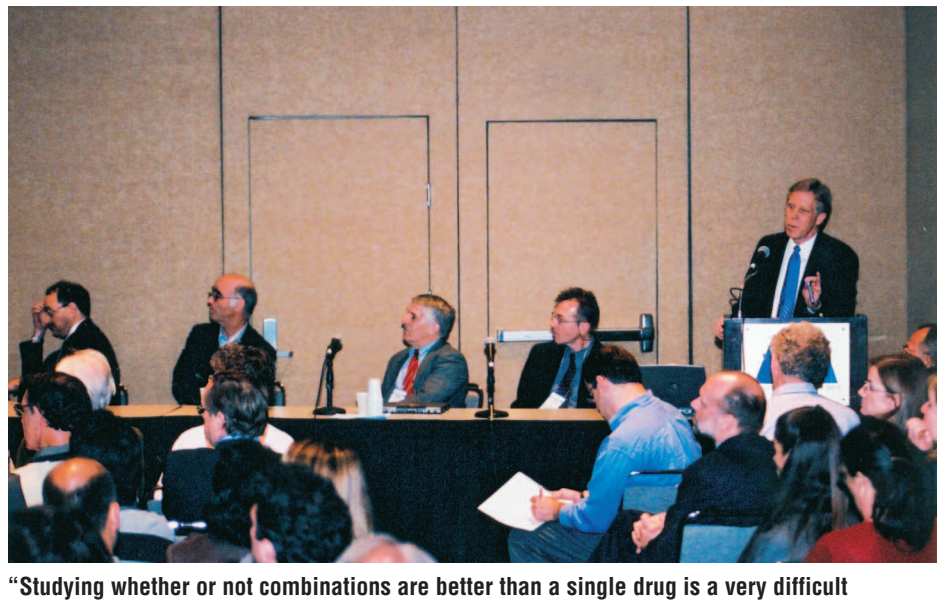
Although WAYPT is an independent body, its founders plan to have it establish a strong, positive working relationship with APA, the European Board of Psychiatry, and the WPA. In fact, Norman Sartorious, M.D., of Geneva, Switzerland, a former WPA president, was on hand before the new organization's inaugural ceremony to give its founders some advice on how to get it up and running.

More information about WAYPT is posted on the Web at <www.waypt.org>. ■

Data Raise Concerns About Polypharmacy Trend

Despite becoming an increasingly common practice, antipsychotic polypharmacy may not be the best approach for patients, evidence suggests.

BY JIM ROSACK



"Studying whether or not combinations are better than a single drug is a very difficult question to tackle," says Donald Goff, M.D. (at podium). He is joined by panelists (from left) Andre Tapp, M.D., Alexander Miller, M.D., Robert Rosenheck, M.D., and William Honer, M.D.

Psychiatrists will say there are a number of reasons why they combine antipsychotic medications, whether the combination is two atypical antipsychotic medications or one atypical with a conventional antipsychotic. Yet among those reasons is probably not something like "It's backed up by the evidence base" or "It's recommended in the practice guidelines."

A workshop last month at APA's 2003 annual meeting in San Francisco on antipsychotic polypharmacy versus monotherapy in patients with schizophrenia attempted to explore two important questions: Why do physicians prescribe multiple antipsychotics? And when a patient is on combination therapy, does the patient generally improve?

The seminar, chaired by Andre Tapp, M.D., chief of psychiatry at the VA Puget Sound Health Care System in Tacoma, Wash., and an associate professor of psychiatry at the University of Washington, drew such a large crowd that even after additional seats were brought in, late arrivals had to stand in the aisles or sit on the floor. If attendance at an annual meeting seminar is any rough gauge, Tapp noted at the outset, antipsychotic polypharmacy is a hot topic.

Not Uncommon, But Right Course?

Prescribing multiple medications to a patient with a severe medical disorder is not, after all, that unusual. In other medical specialties, in fact, it is not only common, but widely accepted and integrated within best-practice treatment guidelines. Cardiologists, for example, often use multiple medication "cocktails" to bring hypertension under control, while pulmonologists do likewise for obstructive pulmonary disease and oncologists for various types of cancer.

Why then would the use of multiple medications to treat a patient with a severely debilitating medical disorder, such as schizophrenia, be such a hot topic of debate? Everyone is looking for evidence to back up the practice.

"In psychiatric practice," Tapp said, "we hear about many psychiatrists who use combination antipsychotic therapy, and we want to understand why physicians do that. How common is the practice of polypharmacy, and do patients actually improve with multiple medications? We really don't know the answers yet."

Tapp was joined at the workshop by Alexander Miller, M.D., director of the schizophrenia module of the Texas Medication Algorithm Project at the University of Texas Health Sciences Center in San Antonio; Donald Goff, M.D., a professor of psychiatry at Harvard University and Massachusetts General Hospital; Robert Rosenheck, M.D., a professor of psychiatry at Yale Medical School and director of the Veterans Affairs Northeast Evaluation Center; and William Honer, M.D., a professor of psychiatry at the University of British Columbia.

More Questions Than Answers

Both Tapp and Rosenheck have explored the question of why clinicians prescribe more than one antipsychotic medication to a patient. And while the two seem to agree on some points, their data may in a way

please see ***Polypharmacy*** *on page 28*

med check

This edition of Med Check features a subset of the nearly 900 new research presentations at APA's 156th Annual Meeting in San Francisco last month. The majority of these items involve investigational uses of medications for indications not yet approved by the FDA. Most of the research presented has not yet been peer reviewed.

COMPILED BY JIM ROSACK

Medications for ADHD

• ***Atomoxetine*** appears to be effective in treating symptoms of emotional dysregulation, such as an inappropriately quick temper, affective lability, and emotional over-reactivity, often seen in adults with ADHD, according to Fred Reimherr, M.D., of the University of Utah School of Medicine and colleagues. In two concurrent multicenter studies involving a total of 451 patients, 31 percent experienced emotional dysregulation, as measured by the Connors' Adult ADHD Rating Scale and the Wender-Reimherr Adult Attention-Deficit Disorder Scale. Atomoxetine significantly improved symptoms of emotional dysregulation with a treatment effect similar to improvements demonstrated in signs of hyperactivity/impulsivity and inattention. (Funded by Lilly Research Laboratories)

Medications for Bipolar Disorder

• Patients with bipolar disorder who are prescribed ***antidepressants*** often are "switched" into mania. Ayal Schaffer, M.D., of the University of Toronto and colleagues reported that this may not be true for elderly patients with bipolar disorder. In a retrospective study, 1,072 elderly patients with bipolar disorder who were prescribed antidepressants were compared with 3,000 elderly patients with bipolar disorder who received no antidepressant medications. Over an average of 440 days of follow-up, patients who received antidepressant medications were half as likely to be admitted to a hospital for an acute manic episode as those not taking antidepressants. In addition, those taking antidepressants were 30 percent less likely to be admitted for depression. Shaffer believes that elderly patients may be "less biologically vulnerable to the switch" induced in younger patients who take antidepressants. (No industry funding)

• ***Valproate*** may have no significant effect on total serum triglycerides, cholesterol, LDL, HDL, and fasting glucose levels, in contrast to some atypical antipsychotics used to treat acute mania that have been associated with significant elevations of lipids and serum glucose levels. In a small retrospective chart review, Susan Leckland, R.Ph., of the University of California, San Diego, and colleagues found that of 935 records examined, only 37 were found to have adequate data on total cholesterol, and not all of those 37 had complete data on the other metabolic factors. However, even though those 37 patients were noted to have gained significant weight resulting in increased body mass index (BMI), no significant changes were found in the data available on any of the metabolic laboratory values. The researchers noted that the significant lack of appropriate data on metabolic factors in the 935 patients indicates that certain aspects of routine medical care, for example, routine monitoring of serum lipids and glucose, are largely lacking in psychiatric settings. (Funded by Abbott Laboratories)

• Extended-release ***carbamazepine*** is effective as a maintenance medication for patients with manic or mixed bipolar disorder, reported Mark Hamner, M.D., of the Medical University of South Carolina and colleagues. In a six-month, open-label extension trial, 77 patients who had previously received either carbamazepine or placebo in a three-week, double-blind trial were given extended-release carbamazepine for an additional six months. Patients who had previously received placebo significantly improved as measured by Young Mania Rating Scale and Clinical Global Impressions scale scores. Improvements seen in the first three weeks for patients taking carbamazepine were maintained with the extended-release formulation through the six-month trial. Adverse events were mild to moderate, including headache, dizziness, and rash, all typical of carbamazepine. No cases of significant weight gain, serious rash, aplastic anemia, or agranulocytosis were noted. (Funded by Shire Pharmaceutical Development)

• ***Oxcarbazepine*** may be effective for the treatment of patients with refractory bipolar disorder, reported Dennis Platt, M.D., of Tallahassee (Fla.) Memorial Hospital and colleagues. The study consisted of a retrospective chart review of 146 patients with bipolar disorder who had either failed or were unable to tolerate previous mood stabilizers and antidepressants. Oxcarbazepine, either as monotherapy or an adjunct to other psychotropic medications, was associated with significant reductions in the patients' scores on depression and mania rating scales. Fourteen percent of patients discontinued oxcarbazepine due to lack of efficacy, and an additional 14 percent discontinued due to adverse events, including nausea, rash, and dizziness. (Funded by Novartis Pharmaceuticals)

Medications for Depressive Disorders

• ***Escitalopram*** is safe and effective for treatment of severe depression, reported Phillip Ninan, M.D., of Emory University and colleagues. In a prospective, double-blind placebo trial, 300 patients with severe depression (a mean baseline score of greater than 30 on the 24-item Hamilton Depression Rating Scale) received either 10 mg to 20 mg of escitalopram or placebo for eight weeks. Escitalopram was statistically significantly superior to placebo in reducing patients' depression ratings on the Hamilton and the Montgomery Asberg Depression Rating Scale, as well as on the Clinical Global Impression scales by week 2 of the trial. The statistical difference between escitalopram and placebo was maintained throughout the trial. Approximately 50 percent of patients taking escitalopram experienced a 50 percent or greater reduction in their depression scores, compared with only 30 percent of those taking placebo. (Funded by Forest Laboratories and Integrated Therapeutics)

• ***Duloxetine*** appears to be associated with less sexual dysfunction than paroxetine, reported Stephen Brannan, M.D., of Lilly and colleagues. In a retrospective analysis of pooled data from four clinical trials, the incidence of sexual dysfunction with duloxetine was significantly lower than with paroxetine in acute-phase trials. In long-term studies the incidence of sexual dysfunction in patients on duloxetine fell between that of placebo and paroxetine. The study utilized the Arizona Sexual Experience Scale, a five-item questionnaire that assesses functioning in a number of areas. Acute data were collected during four eight-week, placebo-controlled, double-blind trials, and long-term data were collected during a 26-week extension phase of two of those acute trials. Duloxetine is a serotonin-norepinephrine reuptake inhibitor. The most common adverse events noted during clinical trials were nausea, dry mouth, constipation, decreased appetite, fatigue, somnolence, and increased sweating. (Funded by Lilly Research Laboratories)

• ***Tamoxifen***, a synthetic, nonsteroidal estrogen antagonist used in patients with estrogen-mediated breast cancer, does not appear to increase a patient's risk of developing depression during treatment for the disease, reported Kelly Lee, Pharm.D., of the University of California at San Francisco and colleagues. Clinical observations had suggested that tamoxifen was associated with an increased risk of depression. In a retrospective cohort study, nearly 3,000 patient records were reviewed to determine whether depression was present at the start of tamoxifen treatment or developed during treatment. A hazard ratio was calculated for tamoxifen and the risk of developing depression due to the medication, and was found to be 1.052. (Funded by Kaiser Permanente Division of Research)

• ***Risperidone*** is a cost-effective adjunct medication in the treatment of Medicaid patients with depression, according to Dennis Meletiche, Pharm.D., of Janssen Pharmaceutica. In an analysis of Medi-Cal (the California Medicaid system) patients with one or more medical claims for depression, augmentation with risperidone or olanzapine was tracked, and utilization of health services and costs were examined. Duration of treatment with either atypical antipsychotic was similar (92.1 days for risperidone vs. 88.4 days for olanzapine), but costs of the medications differed significantly, with risperidone averaging a total cost of $493 vs. $806 for olanzapine. Nearly 63 percent of patients taking risperidone had total mental health costs below the median, while 60.8 percent of patients taking olanzapine had costs above the median. Total utilization of mental health services did not significantly differ between the two groups; however, service utilization prior to initiation of the atypical antipsychotic medication strongly predicted utilization patterns after beginning the medication. (Funded by Janssen Pharmaceutica)

Medications for Psychotic Disorders

• ***Aripiprazole*** is associated with less weight gain and lower risk of elevation of cholesterol and triglyceride levels compared with olanzapine, reported Robert McQuade, Ph.D., of Bristol-Myers Squibb. In a double-blind, multicenter study, 317 patients were randomly assigned to take either aripiprazole or olanzapine and followed for 26 weeks. Efficacy of the two medications was comparable when measured by changes in the Positive and Negative Syndrome Scale (PANSS) total score and scores on the Clinical Global Impression-Improvement scale across the 26-week study. More olanzapine patients experienced a greater than 7 percent increase in weight than patients treated with aripiprazole. Patients on aripiprazole on average lost three pounds, while patients on olanzapine gained more than nine pounds on average. A significantly greater number of olanzapine-treated patients who had normal baseline values for cholesterol and triglycerides experienced elevations in those values compared with patients taking aripiprazole, whose values remained stable. (Funded by Bristol-Myers Squibb)

• ***Ziprasidone*** is as effective but better tolerated than risperidone, according to Donald Addington, M.D., of the University of Calgary in Alberta, Canada. In a double-blind, 52-week head-to-head trial with more than 250 hospitalized patients, ziprasidone and risperidone were found to be equally effective in patients with schizophrenia or schizoaffective disorder. However, patients on ziprasidone had a lower risk of developing a movement disorder, gaining weight, and experiencing elevated prolactin levels. (Funded by Pfizer Inc.)

• ***Long-acting risperidone*** is safe and effective in the maintenance treatment of patients with schizophrenia, data from two studies indicate. In the first study, Martin Turner, M.D., of the Larkfield Centre in Glasgow, Scotland, reported that patients who were stable on conventional depot antipsychotics showed significant reductions in movement disorders and symptoms when switched to long-acting risperidone. In the second study, Stephen Rodriguez, M.S., of Janssen Pharmaceutica reported that long-acting risperidone, when given every two weeks, is effective in both hospital inpatients and outpatients. Severity of movement disorders was mild, and patients experienced little or no pain or discomfort at the injection site. Adverse events noted were consistent with those experienced with oral risperidone. (Funded by Janssen Pharmaceutica) ■

Medication Names and Manufacturers

The following medications were cited in this issue's Med Check feature. The generic name is followed by the brand name and manufacturer.

- **Aripiprazole:** Abilify (Bristol-Myers Squibb/Otsuka)
- **Atomoxetine:** Strattera (Lilly)
- **Carbamazepine extended release:** Carbitrol (Shire)
- **Duloxetine:** Cymbalta (Lilly; pending FDA approval)
- **Escitalopram:** Lexapro (Forest Laboratories)
- **Lamotrigine:** Lamictal (GlaxoSmithKline)
- **Olanzapine:** Zyprexa (Lilly)
- **Oxcarbazepine:** Trileptal (Novartis)
- **Paroxetine:** Paxil (GlaxoSmithKline)
- **Quetiapine:** Seroquel (AstraZeneca)
- **Risperidone:** Risperdal (Janssen)
- **Risperidone long acting:** Risperdal Consta (Janssen; pending FDA approval)
- **Tamoxifen:** Nolvadex (AstraZeneca)
- **Valproate:** Depakote (Abbott Laboratories)
- **Ziprasidone:** Geodon (Pfizer)

Animals Can Model Psychiatric Symptoms

Modeling mental illness in animals has been greeted with skepticism, but despite the obstacles, researchers have made startling progress in reproducing behavioral symptoms in laboratory animals analogous to those seen in humans with disorders.

BY MARK MORAN

Mental illness would seem to be singularly human, a subjectively experienced distortion of consciousness affecting uniquely human attributes: thought, feeling, and language.

For that reason, it presents a unique challenge to the basic scientist seeking to reproduce its symptoms in experimental animals commonly used in the laboratory. Diabetes, high blood pressure, cancer, or other somatic conditions may be reliably replicated, but how does one reproduce depression, anxiety, or delusional paranoia in a laboratory rat?

"Modeling mental illness in animals still seems to many people to be an outrageous idea," Barbara Lipska, Ph.D., of the clinical brain disorders branch of the National Institute of Mental Health (NIMH), told *Psychiatric News*. "People cannot believe that psychiatric disorders can be modeled in a rat or a mouse or a primate because these disorders are believed to be inherently human. Delusions, hallucinations—how are we possibly able to reproduce these symptoms in an animal, and even if we do it, how would we know, since the animals cannot communicate verbally?"

But Lipska and other scientists say that in fact they are able to produce with greater and greater reliability certain behaviors in experimental animals—if not the underlying neuroanatomical or biochemical disorder itself—that are analogous to the behaviors in humans with mental illness and that are the phenomenological reflection of that underlying human disorder.

Daniel Weinberger, M.D., chief of the clinical brain disorders branch, said that new genetic technologies and other refinements are expanding the research potential in animal modeling. Today, scientists at NIMH are modeling schizophrenia in rats and disorders of memory and cognition in mice.

Elsewhere, researchers including Rene Hen, Ph.D., of Columbia University College of Physicians and Surgeons, and Irwin Lucki, Ph.D., of the University of Pennsylvania, are modeling depression and anxiety in laboratory animals.

"You can do experiments in animals that you cannot do in humans," Weinberger said. "The reason we do it is to help us understand underlying disease mechanisms, test causal hypotheses, and find new treatments."

Schizophrenia in Rats

Experimentally reproducing the symptoms of schizophrenia—a complex disorder with a spectrum of symptoms and no definitively known cause—epitomizes both the pitfalls and the possibilities of modeling mental illness in animals.

Lipska and colleagues at NIMH have succeeded in producing an array of symptoms in laboratory rats that serve as surrogates of the symptoms of schizophrenia in humans. Moreover, the appearance of the symptoms mimics in important ways the pattern of the human disorder, providing important laboratory corroboration for developmental hypotheses about its cause.

She explained that rats are particularly suited to modeling a complex disease because they are smarter than mice and are known to be particularly social animals. She and her colleagues have employed a "lesion model," inducing an insult to the rat hippocampus—a region of the brain known to be implicated in human schizophrenia—through the injection of a toxin.

They found that rats with a damaged hippocampus displayed a variety of symptoms analogous to the human disease—hyperlocomotion in response to stress (similar to the vulnerability to stress experienced by many patients), deficits in memory testing (much like the deficits in working memory in humans with the disease), and reduced social contacts (analogous to the social withdrawal exhibited by many people with schizophrenia).

"We can reproduce a constellation of behavioral symptoms," Lipska said. "Schizophrenia is not just one symptom; it's a syndrome of behavioral abnormalities, so we consider it very important to be able to produce an array of behavioral changes. If the model reproduces this constellation of changes, then we can say to a certain extent that it is a good model of the disease."

Serendipity of Model

More important even than the symptoms themselves is the similarity between the pattern of behavioral symptoms in the animals and the pattern of disease as it frequently occurs in humans. It is a remarkable serendipity that would appear to lend support to the "neurodevelopmental" hypothesis of schizophrenia.

The hypothesis holds that schizophrenia begins with a genetic mutation that results, among some who carry the vulnerability, in a defect in development during the third trimester of gestation, when critical brain structures are formed.

This developmental defect may lay more or less dormant until adolescence or early adulthood when the environmental and social stresses of the period begin to overwhelm the individual whose higher brain functions are compromised; it is during this period that many patients experience their first psychotic episode.

Analogously, Lipska and colleagues also saw a dormant period among their lesioned rats, a delay between the introduction of the insult to the hippocampus and the appearance of the behavioral changes. When the changes did occur, it was at a period of the rat's life that correlates with the period of human adolescence, when schizophrenia often appears.

The timing of the insult to the rat hippocampus at seven days after birth—a period of brain development that corresponds to the in-utero period when human brain structures are forming—is likewise crucial. If the toxin is introduced earlier or later,

please see ***Animal Models*** *on page 30*

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Some Parkinson's Patients At High Alzheimer's Risk

Physicians may want to monitor patients with progressive symptoms of Parkinson's disease for the development of Alzheimer's disease.

BY JIM ROSACK

Patients with rapidly progressing signs and symptoms of Parkinson's disease have more than an eightfold increased risk of developing comorbid Alzheimer's disease compared with patients who have little or no progression in Parkinsonian symptoms, according to new research.

In a cohort of more than 700 older persons examined for up to eight years, Robert Wilson, Ph.D., a professor of neuropsychiatry in the department of neurological sciences at Rush Presbyterian-St. Luke's Medical Center and Rush Alzheimer's Disease Center, and his colleagues have found that evidence of Parkinsonian signs at baseline was also loosely associated with an increased risk of Alzheimer's. However, the link between the rate at which those signs progressed and the risk of developing Alzheimer's was significantly more robust.

The study was reported in the April issue of *Archives of Neurology*.

"The new thing in our findings," Wilson told *Psychiatric News*, "is the association to rate of progression of the Parkinsonian signs. The link to baseline presence of signs and increased risk of Alzheimer's has been reported before, and we've replicated that here."

The researchers used data from the Religious Orders Study, a longitudinal study of aging and the development of Alzheimer's in older Catholic nuns, priests, and brothers across the United States. All study subjects, whose average age was 75.4 years, underwent extensive evaluations at baseline, including medical history, neurological examination, cognitive function testing, and reviews of any brain-scan films available.

A diagnosis of Alzheimer's during the study period was determined using the criteria of the joint working group of the National Institute of Neurological and Communicative Disorders and the Stroke-Alzheimer's Disease and Related Disorders Association, documented with an extensive list of cognitive function tests.

Parkinsonian signs were assessed by the Unified Parkinson's Disease Rating Scale (UPDRS). That scale produces an overall rating from zero to 100, with higher scores denoting more signs and symptoms of Parkinson's.

The 770 participants were followed with annual evaluations. Follow-up information regarding the development of Alzheimer's was available for 746 (97 percent) of those participants, with an average length of follow-up of 5.6 years.

Over an average of 4.6 years, 114 of the study participants developed Alzheimer's. (Five other persons developed dementia not related to Alzheimer's and were excluded from the final data analysis.)

An initial analysis of the results revealed that for each point scored on the UPDRS, compared with someone who scored zero on the UPDRS at baseline, the risk of developing Alzheimer's increased 4 percent.

"So, risk of disease was 40 percent greater in a person with a UPDRS score of 10, and 80 percent greater with a score of 20," said Wilson.

When all the data were analyzed, however, the researchers found that by far the more significant correlation between Parkinsonian signs and risk of Alzheimer's was the rate at which the signs progressed. Compared with the 21 percent of the cohort who had no progression on the UPDRS, the risk of Alzheimer's more than doubled in the subgroup with the least progression, more than tripled in the moderate subgroup, and was 8.5 times greater for those with the most rapid progression in Parkinsonian signs.

The study participants agreed to donate their bodies after death for pathological examination. To date, about 250 have died, and about 90 percent of them have been autopsied, said Wilson. So far, patients diagnosed with Alzheimer's during the study have had pathologic evidence confirming the clinical diagnosis.

"We believe there are three possibilities that could explain the link between Parkinsonian signs and Alzheimer's," Wilson said.

First, he said, pathologic changes common to Alzheimer's that occur in the midbrain, specifically the substantia nigra, could be strongly contributing to the development of the Parkinsonian signs. That, he said, would explain both the progressive nature of the signs and their association with the development of Alzheimer's.

Second, other pathology, such as that from cerebrovascular events, could be contributing to development of the Parkinsonian signs. And third, he said, the signs could be due to actual Parkinson's pathology, such as Lewy bodies.

The team of researchers is going through the autopsy data to determine whether any of the three hypotheses is supported.

"The bottom line, though," Wilson said, "is that anyone with Parkinsonian signs must be closely watched and screened for any signs of developing Alzheimer's disease."

An abstract of "Parkinsonianlike Signs and Risk of Incident Alzheimer's Disease in Older Persons" is posted on the Web at <http://archneur.ama-assn.org/cgi/content/abstract/60/4/539>. ■

Long, Sunny Days Linked To Suicide Incidence

Bright sunlight—not temperature, rainfall, or barometric pressure—seems to explain why suicides peak in spring and summer, a new study from Australia suggests.

BY JOAN AREHART-TREICHEL

Now that the longest days of the year are here, at least in the Northern Hemisphere, many people are rejoicing. After all, sunlight is a tonic for most people's mental health, especially for those who suffer from seasonal affective disorder.

Ironically, however, spring and summer seem to have a baleful effect on the psyches of other people. Both the severity of endogenous depression and the incidence of suicide peak in the spring and summer months. The evidence comes from several studies conducted in both the Northern and Southern hemispheres over the past quarter-century.

But what is it about spring and summer that triggers depression or suicide in certain people? It may well be exposure to bright sunlight, an Australian study reported in the April *American Journal of Psychiatry* suggests. The study links suicide not only with spring and summer, but also with the prevailing levels of sunlight.

Gavin Lambert, Ph.D., a research fellow at the Baker Heart Research Institute in Melbourne, Victoria, Australia, and his colleagues reasoned that if severity of depression and suicide incidence peak in the spring and summer, there must be some meteorological cue associated with these two seasons that alters brain activity and thus triggers depression or suicidal tendencies.

To identify that cue, the researchers looked at the frequency of suicide in the state of Victoria in the 1990s and whether suicide frequency could be linked with a particular meteorological factor.

Through the Office of the State Coroner of Victoria and the Victorian Institute of Forensic Medicine, they learned that 5,706 suicides had occurred in Victoria from 1990 to 1999. They obtained detailed meteorological data about the weather in Victoria from 1990 to 1999 from the Australian Commonwealth Bureau of Meteorology in Melbourne. The data included average daily temperatures, average daily atmospheric pressures, daily amounts of rainfall, and hours of bright sunlight daily.

They found that the incidence of suicide was highest in the spring and summer months and lowest in the winter ones. They then looked at whether there was any association between this seasonal pattern and seasonal variations in temperature, atmospheric pressure, rainfall, and bright sunlight. They found a correlation for bright sunlight, but not for the other factors. Seasonal fluctuations in suicides closely paralleled seasonal fluctuations in bright sunlight (see graph). This pattern was particularly marked for violent suicides.

Thus, "the incidence of suicide in southeastern Australia displays a clear seasonal pattern, being positively linked with prevailing levels of sunlight," Lambert and his group concluded.

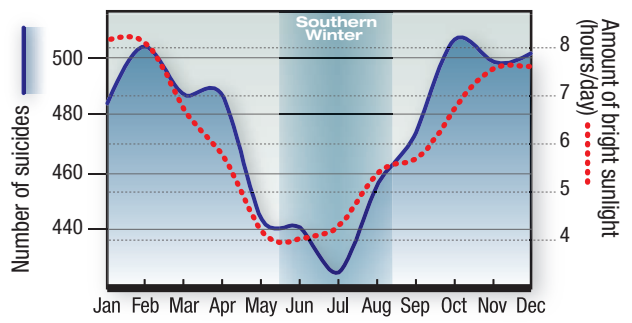
But why? Lambert told *Psychiatric News* that the neurotransmitter serotonin is probably involved, since he and his colleagues have found a link between bright sunlight and brain levels of serotonin in healthy human subjects and since some other researchers have found serotonin disturbances in the brains and cerebrospinal fluids of suicide completers. How serotonin might trigger suicidal behavior in certain people, however, is far from clear.

The investigation was funded by the National Health and Medical Research Council of Australia, the Wellcome Trust, and the Australian Rotary Health Research Fund.

The study, "Increased Suicide Rate in the Middle-Aged and Its Association With Hours of Sunlight," is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/160/4/793?>. ■

A Counterintuitive Corollary

Association between suicide frequency and amount of bright sunlight in Victoria, Australia, 1990-1999*



*Monthly values encompass consecutive three-month periods. For example, values for July were derived from the mean of values for June, July, and August, and values for August were derived from the mean of values for July, August, and September.

Source: *American Journal of Psychiatry*, April 2003

Data Back Relationship Between Serotonin Binding, Suicide Attempts

A new study out of Belgium documents abnormal serotonin receptor binding in the prefrontal cortex region of the brain of a few suicide attempters. It adds ammunition to the case that serotonin abnormalities underlie suicidal behavior.

BY JOAN AREHART-TREICHEL

Do serotonin abnormalities in the brain underlie suicidal thoughts and behavior? Postmortem evidence from the brains of suicide completers indicates yes. So has cerebrospinal fluid evidence from suicide attempters. And now evidence from the brains of a handful of suicide attempters indicates yes as well.

Kees van Heeringen, M.D., Ph.D., chair of psychiatry at the University Hospital Gent in Belgium, and his coworkers have found that serotonin receptors in the prefrontal cortex of nine suicide attempters did not bind as well as did serotonin receptors in the prefrontal cortex of 13 control subjects. They reported their finding in the April *Journal of Affective Disorders*.

"These results compliment our findings," Maria Oquendo, M.D., an associate professor of clinical psychiatry at Columbia University, told *Psychiatric News*. In the January *Archives of General Psychiatry*, Oquendo and her team reported that they had found less serotonergic response to a chemical challenge in the prefrontal cortexes of 16 very suicidal depressed subjects than in the prefrontal cortexes of nine less suicidal depressed subjects.

Still another strength of the study, Oquendo pointed out, is that the researchers focused on those serotonin receptors that have been found to be involved in suicide completion—the 5-HT2a receptors. The study also links poor 5-HT2a binding with hopelessness—a well-documented risk factor for suicide.

The suicidal subjects whom van Heeringen and his colleagues selected for their study were persons who had been admitted to the University Hospital Gent Department of Psychiatry following a suicide attempt. Seven were male, two female. For at least six months before the study, all were free of psychotropic drugs, except for benzodiazepines, barbiturates, or anti-epileptic drugs that were ingested during the suicide attempt. None were substance abusers. Control subjects consisted of seven males and six females who were recruited from the hospital staff and screened for personal and familial psychiatric histories as well as medical histories. None used psychotropic medications or abused substances.

The suicidal subjects were assigned a psychiatric diagnosis according to *DSM-IV* criteria. Four were diagnosed with major depressive disorder, two with narcissistic personality disorder, one with borderline personality disorder, one with dependent personality disorder, and one with brief psychotic disorder. Then both suicidal subjects and control subjects were assessed for personality characteristics using a Dutch version of Cloninger's 240-item Temperament and Character Inventory and for hopelessness according to Beck's Hopelessness Scale. After that, a radioactively labeled chemical that binds selectively to 5-HT2a receptors and brain imaging were used to visualize 5-HT2a receptor binding in all the subjects' frontal cortexes.

The researchers then compared serotonin receptor binding in the suicide attempters with that in the controls. They found that the suicide attempters had a significantly lower binding potential of 5-HT2a receptors in the prefrontal cortex than had the control subjects, especially in the dorsolateral area of the prefrontal cortex, which is involved in anticipation and planning.

The investigators then looked to see whether they could identify any personality traits that characterized the suicide attempters compared with the controls. The suicidal subjects scored significantly higher on harm avoidance and hopelessness and significantly lower on self-directedness and cooperativeness than had the controls.

Finally, the scientists attempted to see whether they could make any statistically significant connections between the low serotonin-binding potential in the prefrontal cortexes of the suicidal subjects and particular personality characteristics that the subjects possessed. A significant link was found between harm avoidance and binding potential and also between hopelessness and binding potential.

Thus, "lower central serotonergic function, hopelessness, and harm avoidance are interrelated phenomena, which may increase the probability of the occurrence of attempted suicide," van Heeringen and his team concluded.

The results, van Heeringen told *Psychiatric News*, also imply that drugs that enhance serotonin activity in the brain might possibly "prevent the occurrence of suicidal behavior through their effect on hopelessness and anxiety regulation."

In fact, Oquendo and her coworkers are exploring the possible value of the SSRIs, as well as of some other medications, in preventing suicidal behavior (*Psychiatric News*, October 18, 2002).

The study by van Heeringen and his colleagues was financed by the Fund for Scientific Research–Flanders.

An abstract of the study, "Prefrontal 5-HT2a Receptor Binding Index, Hopelessness, and Personality Characteristics in Attempted Suicide," can be accessed on the Web at <www.sciencedirect.com> **by clicking on "Browse A-Z of journals," then "j," then *Journal of Anxiety Disorders*.** ■

from the president

continued from page 3

in which "the biological machinery for emotions is largely preset, the inducers are not part of the machinery, they are external to it. . . . In all probability development and culture superimpose the following influences on the preset devices: first, they shape what constitutes an adequate inducer of a given emotion; second, they shape some aspects of the expression of emotion, and third, they shape the cognition and behavior which follows the deployment of an emotion."

The challenge to psychiatric skills lies in working to heal the processes described by Damasio and at any one of a number of the junctures he cites. We can utilize our current knowledge about neurocircuitry and neurobiological processes to better understand goal-directed behavior, as well as the stress that disrupts it, and those factors that enhance or derail it. Our ultimate objective is to create a unified whole in our psychiatric world with a truly biopsychosocial approach to both diagnosis and treatment.

We've come a long way from the days when we could only observe behaviors and appreciate our patients' affects as we listened to their stories. However, we still have a long way to go, and it is essential that all the members of our profession travel that road together. ■

New Diagnostic Tool Validates Alzheimer's-Syndrome Depression

Researchers who first proposed that depression in elderly people with dementia is a distinct form of depression have now developed a tool to diagnose this condition.

BY JIM ROSACK

By developing a new diagnostic tool, a consortium of researchers has collected some of the strongest evidence to date validating the diagnosis of major depressive syndrome of Alzheimer's disease.

For more than 20 years, a number of geriatric psychiatrists and neurologists have suspected that depression that occurs in the context of dementia in elderly people is not the same as depression that occurs in elderly people who are cognitively normal. Now, a landmark study from researchers who first proposed a distinct diagnosis provides solid empirical data based on a standardized, systematic assessment tool.

"All of the patients at each of the sites—which included four National Institute on Aging–funded Alzheimer's disease research centers at the University of California, Los Angeles, the Mayo Clinic, Indiana University, and Mt. Sinai School of Medicine, along with the geriatric psychiatry branch at the National Institute of Mental Health—were given a semi-structured, clinical assessment that we had developed for the diagnosis called the Clinical Assessment of Depression in Dementia [CADD]," said George Zubenko, M.D., Ph.D., a professor of psychiatry at the University of Pittsburgh.

Zubenko told *Psychiatric News* that the development of CADD was a significant step forward in research methodology. Previous reports of depression in the context of Alzheimer's had varied widely as far as prevalence and symptomatology, simply because each used different assessments and variable methodologies.

Zubenko said, "We used common, reliable methodology so that we were all collecting the same information in the same way, using the same sources of both direct and ancillary information from both informants and medical records. Then, having gone through that common methodology for assessment, we applied a common set of diagnostic criteria so that we could establish a diagnosis."

The development of CADD and its validation in 243 patients with Alzheimer's disease and 151 nondemented elderly comparison subjects at the five research centers is reported in the May issue of the *American Journal of Psychiatry*.

Incorporates Existing Scales

CADD is a diagnostic interview that incorporates a structured, anchored version of the 17-item Hamilton Depression Rating Scale that has previously been validated for use in a geriatric population. In addition, CADD includes the subsection of the Neuropsychiatric Inventory that assesses the presence or absence, frequency, and severity of a list of hallucinations and delusions commonly experienced by patients with dementia.

A portion of the Structured Clinical Interview for *DSM-III-R* that scores signs and symptoms required for the diagnosis of major depression is also included, with the end result of CADD being a single, coherent clinical interview that can be completed in approximately 30 minutes. Responses to each item are elicited from each patient, as well as a best informant or caregiver, and includes a final judgment by the trained clinician who conducts the interview and has reviewed available medical records.

CADD also records sociodemographic information, current medications, age at onset of cognitive decline, and the patient's score on the Mini-Mental State Exam, as well as the Clinical Dementia Rating at the time of assessment. Finally, the instrument includes a narrative summary describing the evaluator's diagnostic assessment.

Validating Instrument and Diagnosis

Zubenko and his colleagues report that nearly half (44.9 percent) of the patients with Alzheimer's disease had experienced at least one major depressive episode during their lifetimes, and a third (34.6 percent) developed major depressive episodes at or after the onset of cognitive decline.

In comparison, 28.5 percent of the nondemented patients had experienced at least one major depressive episode, which allowed the researchers to look for differences in the presentation of depression between the two groups of patients.

Significantly, the team found that the largest portion of patients with Alzheimer's disease most likely to develop a major depressive episode were those with the mildest cognitive impairment. Compared with nondemented patients, patients with Alzheimer's disease were significantly more likely to report diminished ability to concentrate or indecisiveness and significantly less likely to report sleep disturbances (either insomnia or hypersomnia) and feelings of worthlessness or excessive guilt. Interestingly, no significant changes were seen in depressive features between mildly, moderately, and severely demented patients.

Zubenko and his colleagues believe that CADD reliably diagnosed and characterized the number and course of major depressive episodes occurring in patients with Alzheimer's disease. The next step, Zubenko said, is to confirm that the CADD methodology is generalizable across patient populations. The underlying question then, he added, is to find out what anatomical or physiological changes are responsible for the unique nature of depression in the context of dementia as differentiated from depression in cognitively normal seniors.

There is evidence, Zubenko noted (including studies he did as far back as the 1980s), that "the major depressive syndrome of Alzheimer's disease is associated with accelerated degeneration of aminergic neurons in the brain stem—the collection of cells that synthesize the majority of the aminergic neurotransmitters—serotonin, norepinephrine, and dopamine."

Those studies, he added, are some of the only evidence that supports the aminergic hypothesis of depression, work that needs to be advanced and expanded.

"Having [validated CADD], we are now across our sites characterizing a large number patients from [other investigators'] longitudiinal cohorts of clinically diagnosed Alzheimer's and their control groups, with the goal being to use our common reliable methodology in a prospective longitudinal way to characterize the emergence of major depressive episodes in these patients," Zubenko said. "The expectation then is, that as patients die, we will be getting their brains and be able to move ahead with neurochemical and pathological studies of the correlates of change that mark this disease."

The study, "A Collaborative Study of the Emergence and Clinical Features of the Major Depressive Syndrome of Alzheimer's Disease," is posted on the Web at <http://ajp.psychiatryonline.org>. ■

residents' forum

Eliminating Restraints

BY JENNIFER HARRIS, M.D.

Mike, an 8-year-old boy with significant cognitive limitations and a history of witnessing domestic violence, is an inpatient on a child psychiatric unit. He walks up to a member of the milieu staff and begins pulling on her arm. The staff member gently asks him to please stop, as this is hurting her. Instead of stopping, he gets more and more agitated, pulling at her more and more forcefully, ignoring verbal redirection. What should the next intervention be?

I recently had the privilege of spending four months on the Child Assessment Unit (CAU) at Cambridge Hospital, a 13-bed unit for children ages 2 to 13, which has managed to eliminate the use of physical, chemical, and mechanical restraints, as well as locked-door seclusion. My time there made me rethink many of my assumptions about the purpose of inpatient care, as well as behavioral interventions. I left convinced that this unit is at the vanguard of a revolution in how we treat agitated and aggressive patients in child psychiatry.

I had heard a great deal about the changes taking place on this unit prior to starting there. As an adult psychiatry resident at Cambridge Hospital, I heard the child psychiatry fellows talking about the transition to a new model of care with great trepidation and concern. How could you keep staff and kids safe if you couldn't restrain someone? How could kids learn to behave properly if they never got consequences for bad behavior? How could you run a unit without the ultimate in limit setting (restraints) as an option? Isn't the purpose of an inpatient unit safety and containment? As a former day care teacher, I believed in the importance of minimal but consistent limit setting.

The answer to these questions starts with rethinking the core mission of an inpatient unit. When the leaders of the CAU started to think about these changes, their first step was to change the mission from safety and containment to nurturance and teaching. On a practical level, this meant the end of formal visiting hours. Parents can (and do) come on to the unit any time of day or night, and may even spend the night with their children, if they desire. They also allow more physical contact between staff and patients. Staff not only give kids high fives and return hugs, they even sometimes initiate them. Walking through the CAU, one immediately notices this difference. Instead of feeling like a structured, contained, even cold environment, it feels warm, friendly, and relaxed.

But the most dramatic changes that were made had to do with the behavior plan—it was eliminated. Instead of an elaborate points system, in which patients had to earn privileges by good behavior, it was assumed that kids would be allowed off the unit once they had been there 24 hours, unless some very good reason otherwise existed. Perhaps most remarkably, there was no set list of consequences for certain behaviors. Every situation was judged independently, at the moment, and interventions were tailored to a particular child at a particular moment.

The unit adopted Ross Greene's concept of Collaborative Problem Solving. Greatly simplified, this program focused on avoiding strict limit setting in favor of compromise and negotiation to help kids understand the reasons for their behavior and practice better ways to get what they need. This has required a far more detailed understanding of each child, what drives his or her behavior, and what helps. Instead of just looking at what a kid is doing, one must understand why. Such an approach forces all the clinicians (from milieu staff to attendings) to formulate cases deeply and to tailor interventions accordingly.

Another staff member approaches and comments that she saw Mike on the phone asking his mother to pick him up at the hospital. It appeared his mother had hung up on him. The two staff members start to talk to Mike about other things he could do if he's feeling upset. Many suggestions are offered, and Mike starts to relax his grip. Eventually Mike agrees that getting out a stuffed animal to hold on to might help. He lets go, and they go to the closet together and pick one out.

This is just one example of the types of interactions I witnessed daily on the CAU during my four months there. It is, however, an excellent example. On a unit more focused on behaviors than the reasons behind them, this could easily have escalated into a restraint. Instead, staff used their knowledge of this child's limitations, his history, and recent events to tailor their intervention in a way that not only de-escalated the situation, but also more directly attended to his needs. I hope that my work as a child psychiatrist will be similarly nurturing, responsive, and effective. ■

Dr. Harris is a first-year fellow in child and adolescent psychiatry at Cambridge Hospital in Cambridge, Mass.

letters to the editor

Clarification

I am concerned that members who read "Psychiatrist in Legal Fight Over Privacy of Records" in the April 18 issue may not fully understand my situation and actions.

The article might be read to suggest that I refused to cooperate with an investigation of the Maryland Board of Physician Quality Assurance (BPQA). Rather, the record clearly documents that I both indicated a willingness to cooperate with the BPQA and requested that the BPQA assist me with an ethical dilemma. Since the patients and the patients' counsels refused to waive their confidentiality privilege, "[Dr. Eist] indicated that he wished to cooperate but. . .was faced with 'conflicting ethical and legal obligations,' " according to Judge Barchi. The judge goes on, "The Respondent [Dr. Eist] suggests that even if everything the Board alleges is correct, the Respondent did not fail to cooperate with the Board's attempt to investigate a complaint against him. I agree. The Respondent did not ignore the subpoena nor did he decline to assist the Board in acquiring what information it might need to investigate the complaint. The Respondent indicated that his patients opposed the release of confidential information and awaited a response from the Board on how to proceed."

Moreover, the judge stated, "I am convinced that the Respondent followed the only ethical course of action available to him under the circumstances. The Respondent did not fail to cooperate; rather he attempted to cooperate while preserving the integrity of the confidential relationship with his patients."

I hope that this clarifies that I appropriately objected to the release of confidential records. The judge's comments show that the Board is caught up in a punitive and destructive power struggle to the detriment of those with mental illnesses and the psychiatric profession.

HAROLD EIST, M.D.
Bethesda, Md.

Language Speaks Volumes

Language is what separates us from goats and various other creatures. How we use our language speaks volumes about who we are, what we think, and even about our values, such as honesty and integrity.

The other day I was reviewing an evaluation from my nurse practitioners. There were 10 actions or behaviors listed; the 10th was, "Demonstrates a customer-focused practice." That pushed me over the edge: I had for years been putting up with the word "client" in reference to patients whom I treat. (I have actually insisted for quite some time that if they see me, they are "patients.")

I looked up the definition of many of these words and also polled a number of my non-M.D. colleagues (we are called "providers"—probably some bureaucratic convenience), asking them when they thought we moved from "patient" to "client" and what they considered the reason for that change.

The timing was placed variously in the 1960s or 1970s. One Ph.D. opined that it was an attempt to "empower" the patient by moving away from connotations of sickness or illness. Actually, the word client is "one leaning on another person (for protection)." This does not sound terribly empowering.

Another colleague surmised that health care professionals working in agencies without a medical presence tended to reject the medical model (in favor of a social model?). Another thought that the impetus for using "client" was an attempt to avoid diagnosing and thus pigeon-holing the person and to "depathologize" mental illness. By the way, the word "patient" means "a person receiving care or treatment."

The probable origin of this movement began with the 1951 publication of *Client-Centered Therapy* by Carl R. Rogers, Ph.D. He chose to use the word "client" "because, in spite of its *imperfections of dictionary meaning and derivation*, it seems to come closest to conveying the picture of this person as we see it" (italics mine). Thus, he summarily dismisses Noah Webster and his followers and decides to shape the word to his specifications. He defines a client as ". . .one who comes actively and voluntarily to gain help on a problem, but *without any notion of surrendering his own responsibility for the situation*" (italics mine).

So, Rogers ascribes a certain motivation to the "client" before he even sees the person. I believe this is called an unwarranted and unsupported assumption. Finally, he notes that to label someone a "client" "avoids the connotation that he is sick," and goodness knows we don't want to be caught treating people who are sick.

This may seem a trivial concern to some; however, playing fast and loose with the language can ultimately lead to dire consequences. If our language usage deteriorates, our culture may follow. Arbitrarily bending the meanings of commonly accepted words and concepts to meet one's own needs should be frowned upon.

Unfortunately, common and persistent usage may prevail in this case. I hope not.

JAMES W. BLEVINS, M.D.
Santa Clara, Calif.

Readers are invited to submit letters not more than 500 words long for possible publication. Submission of a letter implies consent for publication unless otherwise indicated. All letters are subject to editing to meet style, clarity, and space requirements. Receipt of letters is not acknowledged. Send submissions to Letters to the Editor, *Psychiatric News,* APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209; fax: (703) 907-1094; e-mail: pnews@psych.org.

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

clinical & research news

Polypharmacy

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pose more questions than they answer.

In a survey of 1,794 patients in the Veterans Affairs Puget Sound system, Tapp looked at the patients who were prescribed at least one antipsychotic medication. Of those, Tapp found 93 patients (5.2 percent) who were on combination therapy for longer than 30 days. The vast majority of the combinations involved the addition of a conventional antipsychotic to an atypical medication the patient was already taking.

"We then asked physicians what was their intention—what were they trying to achieve with the combination therapy?," Tapp said.

The majority of physicians (74 percent) responded that the conventional antipsychotic was added to try to achieve better control over the patients' positive symptoms. The remainder said the combination was prescribed in response to failure of the previous treatment.

The survey results were published in the January issue of *Psychiatric Services.* In a second study, which has been submitted for publication, Tapp looked at subjects' Positive and Negative Syndrome Scale (PANSS) scores before and after the patients were prescribed a second drug to determine whether they obtained any clinical benefit from the combination.

"Eight weeks after adding the second drug," Tapp said, "the patients' positive core symptoms and negative core symptoms were not statistically any different, but the patients' general psychopathology did improve."

In this study at least, the clinicians' rationale for polypharmacy was not borne out by the PANSS scores, Tapp said.

Rosenheck looked at a sample of more than 78,000 veterans who had been diagnosed within the VA system at least twice as having schizophrenia and also looked for evidence of polypharmacy.

"Across 125 VA medical centers across the country," Rosenheck said, "there was broad variability: Anywhere from 1.5 percent all the way to 40 percent of patients who were taking at least one antipsychotic were prescribed polypharmacy."

Rosenheck looked for any patterns or trends that would predict which patients would receive more than one antipsychotic. He found that older patients, as well as patients who were African American, had a comorbid substance abuse disorder, or had comorbid major depression were less likely to receive more than one antipsychotic, while those who had greater than a 60 percent disability or had been hospitalized in the last year were more likely to be prescribed more than one antipsychotic. Also, patients at research hospitals were more likely to receive combination therapy.

"And this is all a familiar pattern to me," Rosenheck said, "because if you look at something like adherence to dosing schedule guidelines, you see general indicators that the sicker patients not only get higher doses, they get multiple medications."

Rosenheck, who tracked administrative prescription data from 1999 to 2001, noted that the rate of antipsychotic polypharmacy is increasing over time. "This may well reflect the greater use of the atypicals in an atypical/conventional pattern—about 80 percent of the polypharmacy in the VA system is an atypical plus a conventional."

Rosenheck also asked physicians who prescribed more than one antipsychotic what benefits polypharmacy provided. Nearly 85 percent said that the patients were refractory to monotherapy, and 58 percent thought that the patient "needed a little conventional [antipsychotic medication] to get better control of positive symptoms."

Often, said Goff, when a patient is not doing well on a particular drug, the physician prescribes a second drug while tapering off the first drug. But six weeks later or so, when the physician asks the patient which drug worked better, the patient often says that he or she felt best on the combination during the switch.

Unfortunately, there are few hard data to back up clinicians' and patients' perceptions that combination antipsychotic therapy works better. Only a handful of open-label trials and one small placebo-controlled trial have actually looked at whether combination therapy has real benefits. And, Goff cautioned, while there are numerous case reports of benefits from combinations of antipsychotics, most patients who are written up as case reports do not represent the majority; in fact, they are atypical.

Tapp concluded that before prescribing a second antipsychotic to a patient, the physician should take a hard look at the drug the patient is already taking.

"Is the patient on an optimum dose of the drug," Tapp said, "or is the patient failing because the dose is too low?"

Rosenheck added that it is also "important to remember that if a patient is not doing well on a certain medication, you need to look not only at the medication, but also at adding psychosocial interventions." ■

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clinical & research news

Animal Models

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the behavioral changes do not occur or occur differently.

"We have to produce the lesion at a critical time, which shows that—as in the human disease—there is some critical window of vulnerability," Lipska reported.

In similar work, Lalit Srivastava, Ph.D., and colleagues at McGill University School of Medicine in Montreal have experimented with lesion models, but also with modeling changes in neuronal activity in rat brains, reflective of the subtle changes believed to accompany human schizophrenia.

Srivastava told *Psychiatric News* that the effort is an attempt to reproduce more faithfully the complexity of the disease and to address a difficulty with the "lesion model"—namely, that the brains of humans with schizophrenia do not, in fact, show large holes or lesions.

"What we are doing is based on the belief that schizophrenia is not really a frank lesion, but a lot of subtle changes in neuronal functioning," he said. "To follow up this line of reasoning, what we are doing is not killing cells, but simply blocking certain types of neuronal activity."

In particular, Srivastava and colleagues have targeted the NMDA glutamate receptor in circumscribed regions of the brain, especially the prefrontal cortex, believed to be involved in schizophrenia.

After injecting the rat brains with an NMDA-antagonist, known as AB5, the animals are left to develop in their cages. As with Lipska's lesioned rats, Srivastava's rats experienced a delay before the onset of behavioral changes. These changes include diminished social interaction, mirroring the social withdrawal common among humans with the disease.

Srivastava and colleagues have also been able to model some symptoms of schizophrenia using genetically altered mice. (While rats are better animal models because of their superior intelligence and their social nature, the mice genome is more completely mapped than that of the rat.)

He explains that past research published by his laboratory showed that postmortem brain samples of patients with schizophrenia showed decreased levels of a protein known as N-CAM, believed to be involved in neuronal development.

Following up on this finding, Srivastava and colleagues used a genetic "knockout" strategy to delete the gene for N-CAM in experimental mice. The result was that the mice displayed certain behavioral problems analogous to the human disease; in particular, they displayed what scientists call a deficit in "prepulse inhibition of startle."

This refers to a defect, also seen in humans with schizophrenia, in processing of sensory motor information. Healthy people, when tested with a loud or disruptive noise, exhibit a startle reflex; but in test conditions in which the loud noise is preceded by a softer, less-intrusive noise—a warning of sorts—healthy people will be able to modulate their startle reflex to the louder noise.

Not so with some schizophrenia patients; even when they are "warned" by the softer noise, they are unable to inhibit the startle reflex that occurs when they hear the louder noise. So, too, Srivastava's genetically altered mice are unable to inhibit the startle reflex.

But Srivastava noted that research has failed to find a genetic association between the N-CAM gene and schizophrenia, and the postmortem finding in brain samples does not suggest a causative association.

"Gene models have problems because although schizophrenia is a genetic disorder, it is more likely to be due to abnormal action of multiple genes working in concert to predispose an individual to the disease," Srivastava said. "And this predisposition is acted upon by environmental factors to lead to frank schizophrenia."

In just this way are animal models likely to remain incomplete reflections of complex human mental illness. "In contrast to some somatic disorders, modeling psychiatric disorders is also problematic because we don't know all of the causative or pathological hallmarks," he told *Psychiatric News*. "The goodness of a model depends on what we know about the disease. But there is not one schizophrenia, and there may not be one depression. These are a spectrum of disorders, with a range of symptoms and severity.

"What are we modeling?" Srivastava asked. "Are we modeling the total disease? I prefer to think that we are testing hypotheses. Since we don't know the real causes and pathological hallmarks of complex mental disorders, we use animal models to test hypotheses that have been advanced." ■

professional news

Maine

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atric News, February 1, 2002).

Maine appealed to the 1st Circuit Court of Appeals in Boston. The court ruled in the state's favor, saying that the program does not "regulate" the drug companies' interstate commerce and that the effect on the drug industry is not excessive in light of the benefits to be obtained. PhRMA then appealed the case to the U.S. Supreme Court.

In a press release about the Supreme Court decision, PhRMA spokesperson Marjorie Powell said that the association was reviewing the court's "complex, multifaceted opinions."

She continued, "As we review the ruling, we note that Justice Stevens' opinion makes clear that today's decision does not 'determine the validity of the Maine program.' The key issues have yet to be decided by the District Court (where the case was returned to weigh evidence about the burdens and benefits of the program for Medicaid patients)."

According to the National Conference of State Legislators, legislators in 18 states have offered bills to create drug-discount programs similar to that in Maine (see map on page 14).

The Supreme Court decision in* Pharmaceutical Research and Manufacturers of America v. Walsh, Acting Commissioner, Maine Department of Human Services, et al., *No 01-188, is posted on the Web at <http://laws.findlaw.com/us/000/01-188.html>. Information about the decision and related state initiatives is posted at <www.ncsl.org/programs/health/pharm.htm#b>. ■

Uninsured

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Notably, the CBO report refutes the widely disseminated figure of 40 million uninsured, saying the number of Americans without health insurance for an entire year is more likely to be between 21 million and 31 million.

The figure of 40 million comes from the Census Bureau's Current Population Survey, and it more closely approximates the number of people who are uninsured at a specific point in time during the year—not the number who are chronically uninsured, according to the CBO.

"Some people are uninsured for long periods, but more are without coverage for shorter times, such as between jobs," the CBO states. "For example, about 30 percent of nonelderly people who become uninsured in a given year remain so for more than 12 months, whereas nearly 50 percent regain health insurance within four months."

Health policy experts familiar with the report say the picture of the uninsured population painted by the report is well known to insiders but less so to the general public, whose opinions may shape pronouncements and policies by legislators.

"The uninsured population is changing in terms of its membership all the time," said Pamela Short, Ph.D., a professor of health policy and administration at Pennsylvania State University.

She emphasized the CBO's data showing the discrepancy between those who are uninsured for long periods, those who are uninsured at one point during a year, and the total figure for those who are uninsured at any time during a year.

"What that suggests is that among those who are uninsured, half are either moving into or moving out of being uninsured," she told *Psychiatric News*. "There is a lot of turnover."

Irvin Muszynski, J.D., director of APA's Office of Healthcare Systems and Financing, said the CBO report lends precision to figures commonly used to describe the problem of Americans who do not have health insurance. He pointed out, however, that the designation "insured" does not necessarily equate with real access to care—particularly when it comes to mental health care.

"The problem of the uninsured is a continuing and serious one," Muszynski said, "but insurance coverage doesn't mean you have adequate access to quality psychiatric care."

Different Surveys Used

The CBO report breaks the uninsured population into three distinct categories, based on the reporting measures used by three federally sponsored national surveys—the Survey of Income and Program Participation, the Medical Expenditure Panel Survey, and the National Health Interview Survey. All of these yield estimates of the number of uninsured at a particular point in time that are similar to the Census Bureau's Current Population Survey estimate of 40 million.

But the number of people who are uninsured for the entire year is estimated to be 21.1 million by the Survey of Income and Program Participation, and 31.1 million by the Medical Expenditure Panel Survey.

Meanwhile, the number of people who are uninsured at any time during the year—the combination of those who are uninsured all year and those who are uninsured at a particular point in time—is between 56.8 million and 69 million.

The CBO also presents data showing that long spells of uninsurance occur less frequently than short spells, but that they are more likely to be under way at any given time. Looking at spells of uninsurance that began between July 1996 and June 1997, the CBO found, based on data from the Survey of Income and Program Participation, that 45 percent of those spells lasted four or fewer months.

Yet data from the same survey looking at periods of uninsurance that were in progress during March 1998 showed that 78 percent of them had lasted more than 12 months.

"Policies aimed at increasing coverage are most likely to be effective if they consider the distinction between the short-term and long-term uninsured," the CBO states. "For people with short uninsured spells, policies might have the goal of filling a temporary gap in coverage or of preventing a gap from occurring. For people with longer periods without insurance, policies might seek to provide or facilitate an ongoing source of coverage."

Numbers Matter

Short agrees that the distinction has important public policy implications, especially given that there is no apparent political will for establishing universal health coverage. "As long as we are stopping short of covering all the people all the time, then we need to think of uninsurance not as a group of people, but as gaps of time when people are without insurance," she said. This amounts to a "real change of mindset."

Policies that fail to recognize the distinction between short- and long-term uninsurance are liable to cost more than anticipated by creating secondary, unintended effects. She cited, as an instance, the option of giving tax credits for buying insurance, an approach that has been favored by the Bush administration.

While superficially attractive, Short says tax credits "piggyback" on the tax system, which views time as occurring a calendar year at a time. Yet as the CBO report indicates, many of those who would benefit from a tax credit would not in fact be uninsured for the whole year, Short said.

More constructive would be policies that seek to keep eligible Medicaid enrollees on the Medicaid rolls or that provide ways to make the federal COBRA insurance plan, which covers workers between jobs, more affordable.

Short suggested that precision in the use of numbers is important, since the numbers can be used to support varying perspectives. At one extreme is the figure of 60 million uninsured at any point during a year—a figure that might suggest to the comfortable middle class: "This can happen to you."

At the other end of the extreme is the figure of 21 million to 31 million people who are uninsured throughout the whole year—more methodologically precise than the widely quoted figure of 40 million, but one that may understate the problem of recurrent lack of access to medical care.

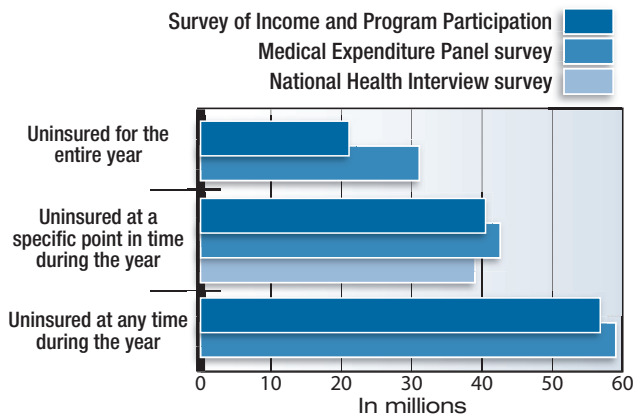
"The size of the problem looks very different depending on how you count the uninsured," she said.

The report, "How Many People Lack Health Insurance and For How Long?," is posted on the Web at <www.cbo.gov/showdoc.cfm?index=4210&sequence=0>. ■

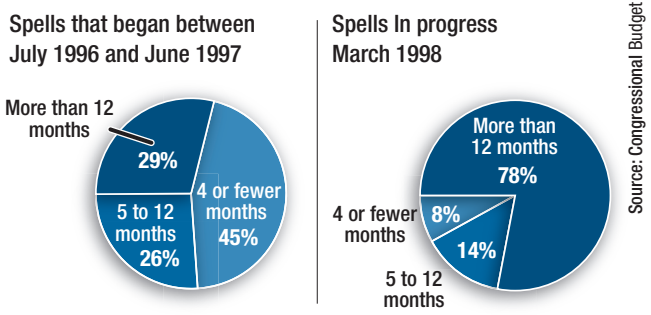
Calculating the Uninsured

The Congressional Budget Office calculates the number of Americans without insurance for an entire year more precisely than the often-quoted Census Bureau's Current Population Survey (CPS) by accounting for people who go through shorter periods without coverage and by doing so over time.

Estimated Number of Nonelderly People Without Health Insurance In 1998



Distribution of Uninsured Spells Among Nonelderly People by Duration



Suicide

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as having a psychiatric diagnosis. Most had a mood disorder and/or a substance use disorder.

Yet earlier data had shown that just 1 percent were actively receiving public mental health treatment at the time, and just 3 percent were taking a psychotropic medication at the time of death. Gray wondered why the majority of the suicide completers weren't in treatment.

When asked to identify the barriers to treatment for their children who committed suicide, parents most frequently cited three factors: their children believed nothing could help them, they were reluctant to admit they had problems, and they perceived seeking help as a sign of weakness. Siblings and friends listed the same problems and added one more—the suicide completers did not know where to go for help.

Acting on his discovery that juvenile justice contact may be associated with suicide, Gray set out to learn more about the adolescents who entered the juvenile justice system in Utah.

Along with his colleagues, he administered the Youth Outcome Questionnaire (YOQ) to the parents of 719 youth who entered the juvenile justice system over a one-month period in 1999.

He found that many of the youth had serious mental health problems: 49 percent had YOQ scores indicating the need for outpatient treatment, and 17 percent scored high enough to need inpatient treatment.

From an analysis of the YOQ scores, Gray learned that "the greater the number of offenses, the worse the mental health."

Last year Gray and his colleagues decided to take what they had learned from the suicide completers and their loved ones and apply it to at-risk youth.

Using the risk factors they pinpointed in their research—repeated contacts with the juvenile justice system and poor mental health as indicated by high YOQ scores—they began a pilot intervention study to prevent youth suicide in the Salt Lake City area. With the close collaboration of the juvenile justice system, the researchers have begun screening and intervening with at-risk youth.

Here's how it works: the researchers, working from a list of adolescents provided to them by the Third District Juvenile Court in Salt Lake City, match adolescents who have similar YOQ scores and ages, as well as the same number of offenses. A flip of the coin determines who enters the study intervention and who receives treatment as usual in the community.

As part of the intervention, the youth receive a psychiatric evaluation and are treated for any mental health problems at the University of Utah Division of Child and Adolescent Psychiatry outpatient clinic. In addition, a treatment team is assigned to work with each adolescent. "As a team, we also address any educational issues and help the adolescent to function better within the community," said Gray.

That the adolescent buys into his or her treatment plan is important, but not necessary, he added. "Even if the teen says, 'I don't want any more of this,' we keep working with the family, as long as we have the parents' cooperation."

"Our motto is, 'within 72 hours, we get someone into your home,' " Gray said, referring to the other aspect of the intervention, an intensive in-home training program for parents of at-risk youth.

The in-home program is the result of a successful collaboration between the Utah Youth Suicide study and Utah Youth Village Families First in Salt Lake City.

Families of at-risk youth may have trouble setting limits with their children, Gray explained, or can't manage their behavior at all. While the treatment team is working with the teen and his or her parents to set limits, a Families First staff member enters the home each day—first, to help with the day-to-day family functioning—and then to provide parents with the skills they need to better manage their adolescents.

"They don't march in and start telling parents what to do," Gray remarked, referring to the in-home service. "They might help with the dishes or drive the young person to his soccer match—they learn everything they can about how your family works, and then they counsel you about the best way to manage your children."

So far, there are more than a dozen families participating in the intervention study, according to Gray, and the researchers have received positive feedback from both parents and children. Preliminary data on the intervention will be available next year.

"We provide the kids with rapid access to psychiatric treatment, in-home support, and case management," said Gray. "We're giving the kids and parents what they need to succeed."

More information on the study can be obtained by contacting Michelle Moskos, Ph.D., M.P.H., by e-mail at mmoskos@utah.gov. ■