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APA Joins AMA to Fight Expected '04 Medicare Cuts

The government's announcement last month of a cut in Medicare physician payment for 2004 heightens demand among physician groups for reform of the way Medicare fees are established.

Government News

BY MARK MORAN

Proposed cuts in Medicare physician payments for 2004 are drawing fire—again—from the AMA and other medical groups.

Reiterating an earlier prediction that physician payments would be cut next year, the Centers for Medicare and Medicaid Services last month announced that physician reimbursement would decrease by an average of 4.2 percent in 2004.

Michael Strazzella, deputy director for congressional relations in APA's Division of Government Relations, said the government ruling was under review, but early indications were that psychiatry would experience an average decrease in payment of 4 percent.

"APA is extremely troubled by the proposed Medicare physician payment reductions for psychiatry and their potential impact on the mentally ill receiving necessary treatment," he said. "APA, in coordination with the AMA, is continuing to advocate for an immediate legislative fix, as well as a long-term solution to the payment formula."

AMA President Donald J. Palmisano, M.D., used the announcement once again to urge reform of the way Medicare fees are established. In the meantime, he called for passage of the House of Representatives' Medicare prescription drug bill, which envisions a 1.5 increase in physician payment in the next two years.

"Recent government-predicted cuts in Medicare physician payments are further evidence of a broken Medicare physician-payment formula and the need for an immediate Congressional fix," Palmisano said. "If the expected cuts in Medicare physician payments are implemented, it could wreak havoc on the ability of seniors and the disabled to get the medical care they need."

The AMA and other groups, including APA, have argued that the Medicare payment formula does not reflect the health care needs of beneficiaries.

please see ***Medicare*** *on page 32*

AP Photo/Gerald Herbert

Wounded U.S. soldiers returning from the war in Iraq are receiving mental health treatment from consultation-liaison psychiatrists at Walter Reed Army Medical Center in Washington, D.C. See story on page 5.

Psychiatrist To Head State's MH Commission

Members in the News

Elizabeth Childs, M.D., the first psychiatrist in two decades to head the Department of Mental Health in Massachusetts, brings multifaceted experience and broad support from mental health advocates to a difficult position.

BY KATE MULLIGAN

Elizabeth Childs, M.D., takes a militant stance toward mental illness. She told *Psychiatric News*, "We're in a fight with mental illness. We can't let it deny people their lives."

With her appointment on June 30 as Commissioner of the Department of Mental Health in Massachusetts, Childs stepped into an arena in which many of the relevant battles will be waged.

Massachusetts, like most other states, faces budget shortfalls and has cut benefits for mental health services and fees to those providing them.

She is already familiar with some of the problems that come with her new job.

As chief and director of psychiatry at Carney Hospital in Dorchester, Mass., Childs learned firsthand of the problems for hospitals that treat large numbers of uninsured patients.

She testified to state officials earlier this year, "Providers. . .who continue to provide services to this population face pressure either to abandon their mission. . .or risk financial collapse and closure, further limiting access."

As immediate past president of the Massachusetts Psychiatric Society (MPS), Childs worked with a committee that advised the state on principles for a Medicaid drug formulary (*Psychiatric News*, May 16).

"Work within the system," she said. "You have to make the big changes from the ground up."

In applying those deceptively simple rules, organizational skills are a big help.

MPS President James Ellison, M.D., told *Psychiatric News* that Childs had helped bring about a reorganization in MPS's committee and office structures.

please see ***MH Commission*** *on page 32*

Election Alert

This issue of *Psychiatric News* went to press before the candidates for APA's 2004 election were announced. That information is now available on APA's Web site at <www.psych.org>.

APA members thinking about running by petition are asked to contact Carol Lewis at clewis@psych.org or (703) 907-8527. Petitions must be received at APA by **Wednesday, October 15.**

SSRI May Be Effective Treatment For Children With Major Depression

Amid recent controversy surrounding the use of antidepressants in children, two clinical trials suggest that sertraline may be an effective treatment option.

Clinical & Research News

BY JIM ROSACK

Sertraline (Zoloft) may be an effective and safe treatment for major depressive disorder in children and adolescents. The finding comes from a report of two randomized controlled trials in the August 27 *Journal of the American Medical Association.*

The report from Karen Dineen Wagner, M.D., Ph.D., a professor of psychiatry and behavioral sciences and director of the division of child and adolescent psychiatry at the University of Texas Medical Branch in Galveston, and from the multinational Sertraline Pediatric Depression Study Group, represents the largest positive medication treatment trial in pediatric depression published to date. Only three other similar clinical trials have been published in peer-reviewed journals, two showing efficacy of fluoxetine (Prozac and generics) and one showing efficacy of paroxetine (Paxil).

Prozac remains the only antidepressant to carry a pediatric indication approved by the Food and Drug Administration (FDA).

Use of antidepressants in pediatric depression has been controversial for some time, but became more so in June when the FDA, along with the British Medicines Control Agency, issued formal warnings to physicians advising against the use of paroxetine in children and adolescents.

The agencies cited a large data set (pooled from nine clinical trials) submitted by GlaxoSmithKline that revealed not only a lack of efficacy—in the opinion of both agencies—but also a potentially significant increase in harmful behaviors, including suicidal ideations and actions (*Psychiatric News*, July 18).

More recently, on August 22, Wyeth sent out a "dear health care professional" letter, reminding physicians that its brands of venlafaxine (Effexor and Effexor XR) are not approved for use in children and adolescents. In addition, the company advised it is voluntarily revising labeling for both medications to include a statement that "safety and effectiveness in pediatric patients have not been established" as well as a warning that clinical trials have noted increased reports of "hostility" and "suicidal ideations and self-harm."

The report by Wagner includes data from two randomized controlled trials in 376 children and adolescents (aged 6 to 17) with *DSM-IV*-defined major depressive disorder of at least moderate severity.

Funded by Pfizer, the trials were undertaken at the request of the FDA under the provisions of pediatric exclusivity and the Best Pharmaceuticals for Children Act (see related article on page 16). Pfizer acknowledged it has received a letter from the FDA saying the company will "likely be able to add the pediatric safety data" to the Zoloft label; however, it was not clear that the company would receive a pediatric indication for the SSRI.

Study patients were randomly assigned to receive either sertraline (50 mg to 200 mg per day) or placebo for 10 weeks. The main outcome measures were the change from baseline on the Children's Depression Rating Scale–Revised (CDRS–R) Best Description of Child total score and any reported adverse events.

Patients who received sertraline saw significantly more improvement in their CDRS–R scores than patients taking

please see ***Children*** *on page 17*

Status of Pediatric Labeling to Date

The FDA's Pediatric Exclusivity program has led to increased information on the safety and efficacy of the following psychotropic medications commonly used in children:

Indicated for pediatric use (Y) Not Indicated for pediatric use (N) Indication pending (P)

***Midazolam** (Versed)*	Y	established efficacy and safety for sedation and antianxiety use with pediatric specific data on dosing and adverse events
***Fluvoxamine** (Luvox)*	Y	established pediatric indication for OCD, with pediatric age and sex specific dosing adjustments
***Buspirone** (Buspar)*	N	efficacy and safety were not established for generalized anxiety disorder, with adult doses resulting in significantly higher blood levels in children
***Fluoxetine** (Prozac)*	Y	established pediatric indication for major depressive disorder and OCD; noted metabolic differences and decreased weight gain
***Venlafaxine** (Effexor)*	N	efficacy in pediatric MDD not established; warning of higher risk of harmful/suicidal behaviors
***Paroxetine** (Paxil)*	N	efficacy in pediatric MDD not established; warning of higher risk of harmful/suicidal behaviors
***Sertraline** (Zoloft)*	P	for pediatric MDD and pediatric adverse event profile (label changes pending final FDA approval)

Source: www.fda.gov/cder/pediatric/labelchange.html (as of August 22, 2003.)

Evidence-Based Treatment of BPD: Not an Oxymoron

BY MARCIA GOIN, M.D.

Hearing the title of my scheduled talk, "Evidence-Based Treatment of Borderline Personality Disorder (BPD)," colleagues kidded me, saying. "Marcia, that's an oxymoron—a concept as paradoxical as 'airplane food' or 'postal service.' 'Evidence?' There's not enough 'evidence' on which to base the treatment of BPD."

This reaction reflects common misperceptions about what constitutes "evidence-based medicine." Similar misperceptions probably prompted David Sackett, one of the founders of the process, to write the paper "Evidence-Based Medicine: What It Is and What It Isn't: Its About Integrating Individual Clinical Expertise and the Best External Evidence" *(BMJ* 1996; 312:71-72).

As Sackett stated, evidence-based medicine is not about making decisions based solely on the results of controlled studies. It is not about providing a cookbook approach or clinging rigidly to algorithms or reifying evidence. It is about being clinically and culturally sensitive and evidence informed. Formulate the question, search for answers, appraise the evidence, apply the results, and assess the outcome.

APA's Practice Guideline Development Process for BPD

The *DSM-III* publication in 1980 was the first time borderline personality was officially defined. In 1989 APA convened a task force to review the possibility of developing a treatment guideline for patients with borderline personality disorder. The group appreciated that such treatment is very difficult; it is associated with severe transference and countertransference problems and has a highly variable outcome. The questions were there, but there was not enough material in the literature to enable APA to develop a treatment guideline.

The question of a guideline was revisited in 1999, at which time there was a fair-sized database that included some randomized controlled studies. The guideline is not as evidence rich as the treatment guideline for bipolar illness, which cites 492 references, but with 198 references, the BPD guideline is certainly not evidence poor. In the BPD guideline, important references to clinical

please see ***From the President*** *on page 30*

APA's Answer Center Meets the Challenge

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

The Answer Center was created in September 1996 to improve member service. It serves as a call center with four representatives fielding incoming calls and either providing an "answer" or locating the appropriate staff person to do so.

When the Answer Center was established, it was staffed by two coordinators and one manager. Over the past seven years, the center's staff has grown from three to five and operates on an annual budget of about $250,000. Its current manager is longtime staff member Wendy Squirrel.

The Answer Center is open Monday through Friday from 8:30 a.m. to 6 p.m. Eastern time to assist members and the general public with a variety of requests. It averages approximately 1,000 phone calls a week through APA's toll-free number at (888) 35-PSYCH, of which 70 percent are member related, 25 percent are from the general public, and 5 percent are from patients. The Answer Center staff is able to handle approximately 90 percent of all calls; they also route an average of about 500 e-mails received at apa@psych.org each month and more than 700 faxes received through the Association's main fax at (703) 907-1085.

Here are some examples of the wide variety of queries received in the Answer Center:

- What are the qualifications for member life status?
- What are APA's CME requirements?
- How many CME credits can I receive for attendance at the annual meeting and the Institute on Psychiatric Services?
- How can I change my mailing information?
- What is my dues balance, and can I pay over the phone by credit card?
- How do I advance to general member status, can I do this over the phone, and how long before the change becomes effective?
- I'm thinking of opening a private practice. Do you have any information on opening a practice?
- Whom do I contact to order an APA appointment book?
- What is my APA member number?

The Answer Center also handles a variety of inquiries from the general public and patients.

In addition, the Answer Center is responsible for fulfillment mailings for other departments within the Association. It assists the Annual Meetings Department by mailing the scientific program submission forms, advance registration packets, and preliminary programs for the Association's two major conferences—the annual meeting and the Institute on Psychiatric Services. For the 2003 annual meeting, the Answer Center mailed out more than 2,000 submission packets and 3,200 advance registration packets to prospective participants. The Answer Center fulfilled 800 requests for the compliance materials for the HIPAA rule on medical record privacy. In addition, the Answer Center mailed numerous copies of the "Career in Psychiatry" brochures for the Office of Education and various other materials to members, staff, and the general public.

The four Answer Center coordinators and one manager are all fully knowledgeable about APA's services, programs, and activities. The coordinators listen attentively and courteously to details conveyed by the caller and then skillfully probe for information to decide whether they can answer the inquiry or need to refer the caller to the appropriate staff for resolution. The manager provides administrative and backup support to the Answer Center.

The Answer Center continues to strive toward the goal of ensuring that both external and internal customers have a positive experience in all their interactions with APA.

Feel free to share your questions, comments, and/or suggestions with me at medicaldirector@psych.com. ■

Association News

APA Wants to Hear From You!

APA President-Elect Michelle Riba, M.D., invites you to suggest APA members for potential appointment to APA's components. Because no president-elect can possibly know all members with a record of expertise in a particular area, your recommendations are very important.

All members in good standing are eligible to serve on APA components. Recommendations should include the member's name, contact information (postal and e-mail addresses and phone and fax numbers), primary practice type (private, academic, public, etc.), the name of the component(s) for which you are recommending the individual, the individual's previous organizational experience (including district branch or APA activities), and area of expertise.

Please speak with suggested individuals to confirm their interest in serving on an APA component.

Send your suggestions by October 15 to Appointments Coordinator, Association Governance, APA, 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209.

Military Psychiatrists Key Part Of Trauma-Treatment Team

The Walter Reed Army Medical Center in the nation's capital had treated more than 200 soldiers injured in Iraq and Afghanistan as of last month. The psychiatric C-L staff are an integral part of the trauma-treatment team.

BY CHRISTINE LEHMANN

When U.S. soldiers are severely injured while stationed in Iraq or Afghanistan, once they are stabilized overseas, they are sent for surgery and rehabilitation to Walter Reed Army Medical Center in Washington, D.C. The teaching hospital has earned a reputation in the military for providing high-quality patient care.

Members of the psychiatric consultation-liaison (C-L) service visit the soldiers daily to establish a therapeutic relationship.

"We want the soldiers to see us as an ally that they can turn to for help," Harold Wain, Ph.D., chief of the psychiatric C-L service told *Psychiatric News.* "We thank the soldiers for serving their country and introduce ourselves as members of the trauma-treatment team. We reassure them that we ask all injured soldiers the same questions."

The average length of stay at Walter Reed is two weeks to one month for most injured soldiers, said Wain. The main types of injuries are shrapnel wounds and severely damaged limbs that require amputation, he said.

Wain estimated that more than 200 U.S. soldiers had been treated at Walter Reed from March, when Operation Iraqi Freedom (OIF) began, to last month. That estimate includes about 40 soldiers from the conflict in Afghanistan.

Wain uses brief therapeutic interventions with the aim of preventing psychiatric stress disorders three or four months later. He honed this approach after the Pentagon was attacked in 2001. He and Maj. Geoffrey Grammer, M.C., an Army C-L psychiatrist, met with hospitalized civilian patients bedside and asked them about their experiences in a nonconfrontational and supportive manner.

"We also used an array of medications and brief interventions including hypnotic and cognitive reframing techniques," said Wain.

"We focus on a person's positive traits during brief psychotherapy to reinforce their resilience. For example, a soldier whose hand was blown off by a rocket-propelled grenade thought to pick [the hand] up and put in his gas mask for safekeeping so we could later reattach it. Another soldier who came under hostile fire remembered to put a tourniquet around his injured leg bone. Having a sense of humor also helps soldiers cope with their injuries," said Wain.

Walter Reed is receiving between 30 and 40 OIF casualties a week. Many soldiers display symptoms of acute stress disorder including hypervigilance, startle responses, flashbacks, and sleep disturbances, said Wain. The C-L staff explain to injured soldiers that these are normal reactions to a traumatic event and should disappear soon with treatment.

"If the symptoms become more frequent or severe, we ask them to contact us, and we can provide a referral to a local psychiatrist. We also call soldiers 30 and 90 days postdischarge to get an update," Grammer told *Psychiatric News.*

The C-L service has diagnosed a handful of soldiers since March with posttraumatic stress disorder (PTSD). "They had severe injuries and prolonged stays in the intensive care unit," explained Grammer.

He uses hypnotic techniques including visual imagery to augment analgesics for soldiers experiencing uncomfortable physical sensations after their limbs are amputated. "One soldier who experienced 'phantom limb' said he felt his toes were crossed and he couldn't uncross them. I taught him a hypnotic technique that distracted him from that sensation," said Grammer.

Amputees typically have to adjust their daily routines and activities once they return to their communities. "We help them anticipate what chores or athletic activities they can't perform and suggest alternatives," said Grammer.

He talks frequently with family members who are staying near the hospital. "I ask them about the soldier's circumstances and how they're coping. I give them permission to take care of themselves because they can be so focused on their loved one that they forget about their own needs. I also mention the family support group to them to help ensure they can support the soldier's recovery," said Grammer.

The C-L service also provides support groups for recovering soldiers, in addition to individual counseling. ■

Support the Foundation

Do you buy electronics, clothes, and airline tickets online? Do you shop with retailers such as Best Buy, Travelocity, Expedia, Hotwire, Priceline, Gap, Dell, Kenneth Cole, Old Navy, Petco, and 1-800-Flowers?

If you do, then you can support the American Psychiatric Foundation at the same time by making one extra click that connects with these retailers through BuyForCharity.com at <www.buyforcharity.com/allcategories.asp>.

A percentage of each sale (up to 35 percent) will be contributed to the foundation. The funds will be used to support the foundation's programs in education and research that are raising awareness of mental illness and increasing access to quality care.

More information is available by contacting Meghan Sayer at the foundation at MSayer@psych.org.

States Find Parity Affordable: Managed Care Gets Credit

Data on the costs of mental health services provided under parity mandates in South Carolina and Vermont show that guaranteeing employees this type of coverage adds very little to insurance bills.

BY KEN HAUSMAN

When South Carolina implemented an insurance parity mandate covering mental health care for state employees in 2002, and Vermont did so in 1998 for all its citizens, they did so in the face of dire warnings from employers and the insurance industry that skyrocketing costs were an inevitable consequence of parity laws.

Data recently reported from both states show that those alarms were false, though both states attribute parity's minimal cost increases to the implementation, along with parity benefits, of plans to manage mental health and substance abuse care.

In July South Carolina released data comparing the claims experience in its first parity year—2002—with those of the last mandate-free year.

State officials reported that adding a mental health care parity requirement that included cost controls through managed care did not even add 1 percent to the costs incurred by the insurance plan.

The annual dollar increase attributable to the parity mandate was $16.65 per insured person, which translates to an overall cost increase of just .76 percent.

The total costs for all types of services covered by the state-sponsored health insurance plan increased by 8.86 percent in the first year of parity coverage. Without the mental health care mandate included, the increase would have been 8.10 percent.

This low percentage increase is significant because the statute establishing South Carolina's parity plan set a cost-increase threshold of 3.39 percent. If cost increases linked to the added mental health care coverage had exceeded this amount, the parity mandate would have come to an end. Since the ceiling was not breached, the mandate remains in effect at least through the 2004 plan year.

Richard Harding, M.D.: "Parity. . . for treatment of mental illnesses, including substance abuse, is providing improved care without the sky falling, as the insurance industry predicted."

Sky Did Not Fall

The first-year data show that parity "for state employees for treatment of mental illnesses, including substance abuse, is providing improved care without the sky falling, as the insurance industry predicted," Richard Harding, M.D., professor and interim chair of the department of neuropsychiatry and behavioral sciences at the University of South Carolina School of Medicine, told *Psychiatric News*. Harding is also a former president of APA.

"The increase in utilization is marginal and doesn't even take into account the offset [in reduced usage] of other medical services," Harding said.

When the parity law went into effect on January 1, 2002, state officials contracted with the mental health carveout firm APS Healthcare to manage the health insurance company's mental health care component. The managed care company is responsible for all services that beneficiaries obtain through psychiatrists and mental health professionals or from hospitals that provide mental health care services.

The plan's medical claims administrator, Blue Cross and Blue Shield of South Carolina, continues to have responsibility for mental illness treatment claims if the services are provided by a physician who is not a psychiatrist or mental health specialist.

State officials attribute the minimal cost increases linked to the parity mandate to the decision to use a "behavioral health management firm" to control mental health care.

"It is thought that the 'managed care' approach taken by the plan with respect to mental health parity—hiring a separate administrator and requiring authorization of all services through that administrator—is responsible for the incremental costs falling well below the estimate embodied in the statute," said Rob Tester, assistant director of the South Carolina Budget and Control Board's Office of Insurance Services.

He added, however, that the second year in which a new insurance benefit is offered is when costs often show a substantial increase, so the next years' claims experience for mental health care will be closely monitored.

Despite the encouraging first-year cost data, the parity mandate will expire at the end of 2004 unless the state legislature votes to extend it. Harding noted that the South Carolina Psychiatric Association has already begun working with lawmakers, advocacy groups, and other professional groups to ensure that the mandate is made permanent. South Carolina does not have a law requiring mental health care parity for citizens other than state employees.

Mixed News in Vermont

In Vermont state officials earlier this month received a report by the federal Substance Abuse and Mental Health Services

please see ***Parity*** *on page 30*

Disease Management Strategies May Work With MH Care

Demonstration projects in disease management are being tested in the fee-for-service Medicare program. Mental illness, though not specifically targeted, could fit the disease management model that has proven successful with other chronic conditions.

BY MARK MORAN

Small-scale disease management (DM) projects currently being tested by the Centers for Medicare and Medicaid Services (CMS) could serve as a catalyst for more widespread use of DM in the public sector.

While there are unique challenges to making DM work in public programs, the concept holds promise for cost-effective improvement in health outcomes for chronically ill beneficiaries, said Sandra Foote, director of the Health Insurance Reform Project at George Washington University. The project is funded by the Robert Wood Johnson Foundation.

Foote wrote the report "Population-Based Disease Management Under Fee-for-Service Medicare," which appeared in the July *Health Affairs*.

She told *Psychiatric News* that though specific disease management programs for mental illness are not envisioned in the Medicare program, and are relatively uncommon in the private sector, there is a significant opportunity for effective management of chronic mental illness.

Foote cited data from a previous study by the Health Insurance Reform Project showing that mental illness is a major driver of costs among the under-65 population in Medicare. And leaders of DM programs for mental illness that do exist in the private sector and in the Medicaid program say that mental illness fits the model of DM that has proven successful with asthma, diabetes, chronic obstructive pulmonary disease, and other chronic conditions.

Foote observed that the venture into DM marks not only a new direction in the clinical care of public-sector patients, but also in the role of CMS.

Government Role Shifts

Traditionally, that role has been to set fees, pay claims, and administer programs, but with the initiation of DM programs, CMS is making a significant shift toward quality improvement and management of clinical services, she said.

"This is fairly new and is a response to the fact that there are complications and comorbidities associated with chronic disease that can be made less costly and less devastating if they are managed better," Foote said. "Fragmentation of care and lack of support for patient self-care are major problems in the fee-for-service Medicare program. Physicians typically don't have timely, accurate, and complete patient information because the care is so fragmented."

Drug Companies Launched DM

DM was introduced in the early 1990s by pharmaceutical companies as a way to increase patients' compliance with medication—and, some would say, to increase pharmaceutical sales.

It has since evolved in the private sector into a competitive industry in which private companies contract with health plans to offer comprehensive support services for specific chronic-disease groups. Companies that offer DM are typically paid a fee by a health plan in return for a guarantee of savings.

As Foote noted, DM programs vary widely in the private sector, but they typically offer the following services as part of a hybrid of beneficiary and physician support services: periodic phone calls from program staff, such as registered nurses; personalized goal-oriented feedback on self-care; access to 24-hour nurse call centers; and educational materials by mail, Internet, or video.

Physicians Receive Alerts

Physicians may also receive alerts when patients need medical attention, reminders when preventive services are overdue, and periodic patient-status reports. Some DM programs have expert clinical information systems that integrate evidence-based clinical guidelines with participants' data from multiple sources, such as claims data and self-reports.

"The key concept is the identification of populations whose outcomes are not good and for whom there is evidence that they are not getting the support they need to better adhere to evidence-based care, including self-care," Foote told *Psychiatric News*.

Last year CMS announced a three-year demonstration project for DM of beneficiaries with advanced-stage congestive heart failure, diabetes, or coronary heart disease.

"This demonstration can help us learn how well these programs work and how best to make these services available to Medicare beneficiaries," said Health and Human Services Secretary Tommy G. Thompson at the time.

Thompson said that studies have shown that a relatively small number of beneficiaries with certain chronic illnesses account for a disproportionate share of Medicare expenditures. Patients with these conditions typically receive fragmented health care across multiple providers and multiple sites of care, and they often require repeated, costly hospitalizations.

The demonstration project was authorized by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).

Foote noted that in addition to the BIPA projects, there are a number of other "coordinated care" demonstrations authorized by Congress in the Balanced Budget Act of 1997, a capitated DM demonstration recently initiated by the Bush administration, and an end-stage renal disease management demonstration.

"It is a rapidly evolving field," Foote said. "People are trying to figure out ways to do DM in the public sector that respond to patient-privacy concerns and that respect the traditional role of the physician."

But she said the demonstration projects initiated by CMS are probably too small to provide much insight into how well DM would work on a program-wide basis. "Many of them are being tried in settings

please see ***Strategies*** *on page 30*

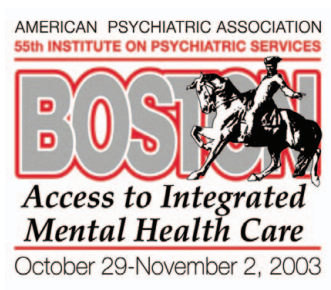
Psychiatrists Debate Ethics Of Drug Marketing

A debate at APA's Institute on Psychiatric Services next month will focus attention on the marketing practices of pharmaceutical companies.

BY KATE MULLIGAN

Escalating costs of prescription drugs loom large in debates about Medicare and Medicaid and have led to heated discussions about the appropriate role of pharmaceutical companies in marketing their products.

In response to this interest, the Scientific Program Committee of APA's Institute on Psychiatric Services will offer a debate, "Resolved: It is Unethical for Psychiatrists to Invite Sales Representatives to Market Products Through Such Methods as Educational Materials, Samples, and Gifts in Clinical Settings," at the institute, which is being held October 29 to November 2 in Boston.



Committee member Charles Huffine, M.D., told *Psychiatric News* that no issue raises more passion among community psychiatrists than the propriety of pharmaceutical companies trying to influence the clinical decision making of psychiatrists.

Huffine is the immediate past president of the American Association of Community Psychiatrists.

Community psychiatrists are in a bind, he said, because they are acutely aware of the effect of prescription drug costs on patients with low incomes and disturbed about the role of marketing in driving up those costs.

Good relationships with pharmaceutical representatives can be important, however, because they help provide access to prescription drugs through samples and assistance in enrolling low-income patients in programs that provide free drugs.

The Blue Cross and Blue Shield Association released a report, "Getting Doctors to Say Yes to Drugs: The Cost and Quality Impact of Drug Company Marketing to Physicians," that compiles results from various studies and surveys exploring issues related to the marketing practices of pharmaceutical companies.

Using data reported by the Kaiser Family Foundation, report authors Michael Millenson and Mervin Shalowitz, M.D., stated that spending on detailing grew by approximately $1.8 billion between 1996 and 2000 and totaled $15.7 billion in that year (see chart).

Detailing includes various practices by which sales representatives present pharmaceutical products to physicians.

"Detailing pays off for companies even at very high levels of expenditure," according to a study reported by the authors.

Scott Neslin, professor of marketing at Amos Tuck School of Business at Dartmouth College, analyzed the marketing of 391 drugs with revenues of at least $25 million each during the period of 1993 to 1999.

He measured the average return on investment (ROI) that resulted from increasing the budgets of four major marketing strategies: detailing; direct-to-consumer advertising, medical-journal advertising, and physician meetings and events. Detailing yielded an overall ROI of $1.72 for each extra $1 invested.

Charles Goldman, M.D., who will present the affirmative position at the institute debate, told *Psychiatric News* that he will be raising issues about detailing, which he described as "a highly sophisticated process that utilizes detailed data on individual prescribing patterns and other characteristics of each physician."

Goldman asserted, "Pharmaceutical company representatives' use of gifts, such as food and samples, and of highly biased instructional materials is strategically linked to the data in each physician's profile."

He said that "an even bigger problem is that the pharmaceutical industry influences, directly or indirectly, much of the published research on treatment alternatives and efficacy. The problem is not with the pharmaceutical industry as such, but with the relative lack of psychiatric leadership opposing these practices and urging independent control of research and education by unbiased psychiatric professionals."

Michael Silver, M.D., who will present the negative position in the debate, told *Psychiatric News* that physicians, not pharmaceutical companies, are ultimately responsible for what they prescribe.

"The drug companies are not doing anything illegal," he said. "They are maximizing their profits, as do other companies in a capitalistic society."

Silver added, "There are few incentives within the current health care system for physicians to be cost-effective in their prescribing habits."

The business aspects and costs of health care have been ignored by patients and doctors alike until fairly recently, he argued.

The Millenson and Shalowitz report noted that marketing can have a positive educational effect. They wrote that a "key question" is the "extent to which the industry's promotional tactics lead to an increase in appropriate use versus inappropriate use of drugs by patients."

A meta-analysis of the literature, "Physicians and the Pharmaceutical Industry: Is a Gift Ever Just a Gift?," concluded that "interactions with pharmaceutical representatives" are linked to "nonrational prescribing, . . .rapid prescribing of new drugs, and decreased prescribing of generic drugs." The study appeared in the January 19, 2000, *Journal of the American Medical Association.*

Researchers found a similar pattern in Great Britain. In the article "Characteristics of General Practitioners Who Frequently See Drug Industry Representatives: One National Cross-Sectional Survey" in the May 31 *British Medical Journal,* C. Watkins and colleagues reported that frequent contact with a drug representative "was significantly associated with a greater willingness to prescribe new drugs and to agree to patients' requests to prescribe a drug that is not clinically indicated. . . ."

The authors mentioned the use of "broad-spectrum antibiotics" as an example of a situation in which pharmaceutical promotion "may impose serious costs."

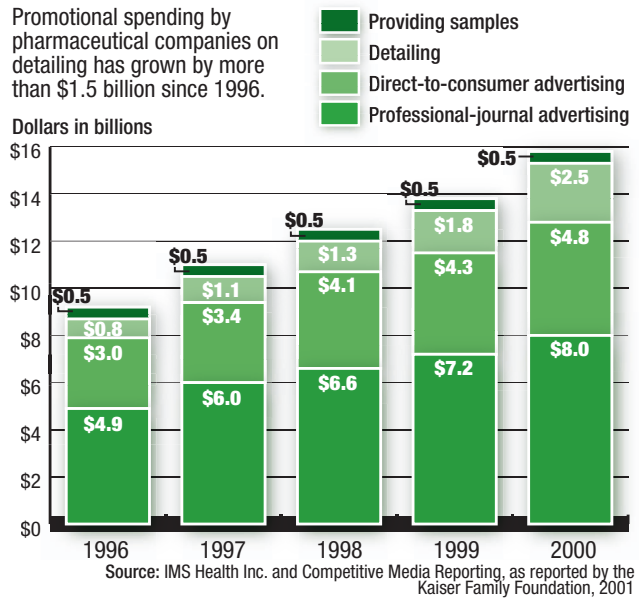
Analysis of National Ambulatory Medical Care Survey data in the April 1 *Annals of Internal Medicine* found that since 1991 physicians have increasingly turned to "expensive, broad-spectrum agents, even when there is little clinical rationale for their use."

An editorial in the same issue singled out the promotional activities of pharmaceutical companies on behalf of broad-spectrum antibiotics as "a cause for concern."

"Getting Doctors to Say Yes to Drugs: The Cost and Quality Impact of Drug Company Marketing to Physicians" is posted on the Web at <http://online pressroom.net/bcbsa/>. ■

Selling Their Wares

Promotional spending by pharmaceutical companies on detailing has grown by more than $1.5 billion since 1996.



Source: IMS Health Inc. and Competitive Media Reporting, as reported by the Kaiser Family Foundation, 2001

Bill Calls for Multimillion-Dollar Study Of Medication Cost-Effectiveness

Bipartisan legislation that would authorize $75 million for government-sponsored research on the cost-effectiveness of prescription drugs has been introduced in the House of Representatives.

BY KATE MULLIGAN

Members of the House of Representatives have made yet another effort to solve problems resulting from the high cost of prescription drugs.

In July they voted to provide $12 million to the U.S. Public Health Service to conduct "research on the comparative effectiveness of prescription drugs."

The funds are part of a health appropriations bill (HR 2660), which will be subject to conference deliberations with members of the Senate later this year.

Rep. Jo Ann Emerson (R-Mo.) led the effort resulting in House passage of the Pharmaceutical Market Access Act of 2003 (HR 2427), which would legalize reimportation of FDA-approved prescription drugs from specified foreign countries *(Psychiatric News*, August 15). That legislation also is subject to conference deliberations with the Senate.

Tom Allen (D-Maine) and Emerson have cosponsored the Prescription Drug Effectiveness Act of 2003 (HR 2356), which would authorize spending $75 million by the National Institutes of Health and the Agency for Healthcare Research and Quality on studies of the "comparative effectiveness and cost-effectiveness of prescription drugs that account for high levels of expenditures or use by individuals in federally funded health programs."

On August 23 the *New York Times* reported that the legislation is supported by Rep. Nancy Johnson (R-Conn.), chair of the House Ways and Means Health Subcommittee. She said that the proposal was "absolutely key to reducing the cost of drugs."

Organizations supporting the proposal include Rx Health Value (a coalition of employers, patients, and insurers that includes AARP, General Motors, Kaiser Permanente, and the American Academy of Family Physicians), Consumers Union, and Families USA.

The Pharmaceutical Research and Manufacturers of America sent a memorandum to members of Congress opposing the legislation. According to the *New York Times*, these were among their points:

- The federal studies would almost certainly influence private insurers. "As a result, the government's cost-based decisions about medical access would be imposed on many patients in both public and private health plans."
- Cost-effectiveness studies show which drug works best, on average, for large numbers of patients, but the studies often overlook the value of specific medicines for individuals or subgroups, like racial minorities.
- Federal studies could stymie "incremental innovation."

Psychiatrist Robert Rosenheck, M.D., told *Psychiatric News*, "There have been a remarkable number of recent studies showing that the source of funds for a study has a strong impact on both its results and recommendations. This effect is particularly true when commercial interests are involved. This initiative could provide less-biased research results. But we should not expect that costs will necessarily go down. The more expensive medications might be more effective. What is important is that value—the health benefit per dollar spent—will go up." Rosenheck is director of the Department of Veterans Affairs Northeast Program Evaluation Center in West Haven, Conn., and a professor of psychiatry at Yale University.

The bill was referred to the House Committee on Energy and Commerce. ■

Large Jury Awards Blamed For Malpractice Premium Surge

A number of factors contribute to increasing medical liability premiums, including insurance company investment losses. However, increases in malpractice awards are the leading cause.

BY MARK MORAN

The causes of rising medical liability insurance premiums nationwide are several and complex, but it appears that the most potent factor is the sharp increase in court awards, according to a report by the U.S. General Accounting Office (GAO).

The GAO's review of the medical-malpractice marketplace nationwide and in seven specific states found multiple factors behind the steep increase in liability insurance that has caused some hospitals and physicians to cut back on services or—in rare cases—to halt services altogether.

But the most prominent cause appears to be insurers' losses on malpractice claims, the GAO said in its report, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates."

"Since 1998 insurers' losses on medical-malpractice claims have increased rapidly in some states," the report stated. "For example, in Mississippi the amount insurers paid annually on medical-malpractice claims, or paid losses, increased by approximately 142 percent from 1998 to 2001 after adjusting for inflation.

"We found that the increased losses appeared to be the greatest contributor to increased premium rates, but a lack of comprehensive data at the national and state levels on insurers' medical-malpractice claims and the associated losses prevented us from fully analyzing the composition and causes of those losses," the GAO stated.

Tort Reform More Needed Than Ever

The AMA cited the report as evidence of the need for tort reform and as a refutation of claims by opponents of reform—especially the trial lawyers association—who say the real reason for rising rates has to do with insurance company investment strategies. Those opponents say that insurance company premiums were artificially low during the bull-market years of the 1990s, when insurance companies were reaping profits from investments; now rates are rising to cover losses as investment income has decreased.

Not so, according to the AMA. "Today's GAO report confirms what we have long held, that since 1999 medical liability premiums have skyrocketed in some states and specialties—and increasing awards are the main driver," said AMA President Donald J. Palmisano, M.D. "Today's report also puts to rest two other trial-lawyer smokescreens: that insurance company gouging and/or stock market losses have caused the medical liability crisis."

Palmisano cited the GAO's report stating that bonds make up 80 percent of insurers' investments and that "no medical malpractice insurers experienced a net loss on their investment portfolios."

And he drew attention to the report's finding that insurer "profits are not increasing, indicating that insurers are not charging and profiting from excessively high premium rates."

"The GAO report also notes that insurance regulators in most states have the authority to deny excessive premium rates," Palmisano said.

"The medical liability crisis in this country cannot be ignored," he continued. "The debate in the Senate is not over whether the medical liability system is in crisis—but rather how we will solve this crisis. Today's GAO report points to the main culprit: increasing awards. The reasonable cap on noneconomic damages that has been working in California is clearly the answer to the crisis."

Seven States Surveyed

The GAO sampled seven states—California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania, and Texas—and compared state and national trends. Within each state, the GAO interviewed one or both of the two largest and currently active medical-malpractice insurers, the state insurance regulator, and the state association of trial attorneys.

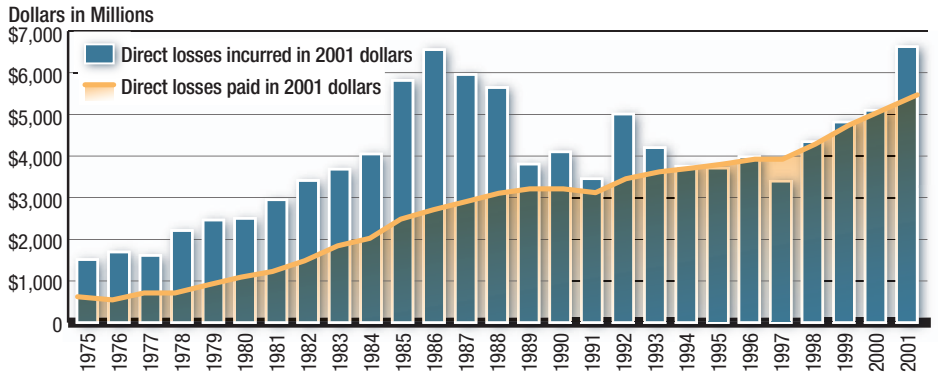
To analyze the factors contributing to the premium rate increases in the sample states and nationally, the GAO reviewed data provided by medical practice insurers to state insurance regulators, the National Association of Insurance Commissioners (NAIC), and A.M. Best, a firm that rates insurance companies' overall financial strength.

While the report emphasized the role of increasing malpractice awards, the GAO does indicate that investment strategies and a host of other factors can influence the li-

please see ***Malpractice*** *on page 33*

25 Years of Increasing Losses

This chart shows dollars paid and losses incurred for the national medical malpractice market, from 1975 to 2001.



Source: "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," GAO Report, June 2003

States Find Creative Ways To Fund Public-Sector Care

State officials show ingenuity in finding federal Medicaid dollars for public psychiatric hospitals, despite a longstanding prohibition against funding inpatient care for adults. The fixes, however, might be temporary.

BY KATE MULLIGAN

Advocates often cite the Institutions for Mental Illness (IMD) exclusion as an example of legislation that works to hamper efforts to serve people with mental illness.

The IMD exclusion prohibits Medicaid reimbursement for inpatient care provided to individuals between the ages of 22 and 64 if the care is delivered in a psychiatric institution that contains 16 or more patient beds. It was intended to support the policy that states, rather than the federal government, have responsibility for funding long-term psychiatric care, particularly for adults.

Representatives of major mental health organizations, such as the National Alliance for the Mentally Ill, told members of President Bush's New Freedom Commission on Mental Health last year that the IMD exclusion has outlived any usefulness and serves to fragment the delivery of mental health care.

A 2003 report from the Substance Abuse and Mental Health Services Administration titled "Medicaid Financing of State and County Psychiatric Hospitals" suggests, however, that state officials and hospital administrators have found various other sources of Medicaid revenue that soften—at least, temporarily—the potentially harsh consequences of the exclusion.

In fact, researchers from Mathematica Policy Research Inc. estimate that in 2001 $2.6 billion in Medicaid funds were paid on behalf of public psychiatric hospitals in the United States. The figure represents approximately one-third of total operating costs for those institutions.

Approximately $2.2 billion of those funds came from Medicaid's Disproportionate Share Hospital (DSH) program. The program provides payments to hospitals that care for a large volume of poor patients. States have discretion in determining hospitals' eligibility for DSH payments. Hospitals must receive DSH payments if their low-income utilization exceeds 25 percent and may receive designation if the Medicaid utilization rate is at least 1 percent of total bed days.

Like other programs funded through Medicaid, federal DSH payments must be matched with state funds according to a formula that reflects the wealth of the state.

Report authors included more detailed analysis of the role and sources of funding for public psychiatric hospitals in Arkansas, California, Iowa, Maryland, and New Jersey.

There is considerable variation among the states in terms of their aggressiveness in claiming DSH funds and their methods of distributing them. In Maryland and New Jersey, for example, state psychiatric hospitals are totally funded by state appropriations. In Maryland, DSH funds go to the state general fund rather than to the hospitals. In New Jersey, DSH funds are earmarked for charity care and hospital-relief funds.

Not surprisingly, given the otherwise limited resources available for public psychiatric hospitals, the size of the DSH program has increased dramatically. Expenses rose from a total of $1.4 billion in payments with six participating states in 1990 to $15.9 billion in 2001 with 47 states and the District of Columbia as participants.

The program cannot be viewed, however, as a long-term funding solution for long-term psychiatric care. Congress has acted to curb the growth in the DSH program. Members limited expenditures to 1992 levels for "high DSH" states and in 1997 capped spending on IMDs at Fiscal 1995 levels and also set standards that would result in a declining percentage of DSH funds going to IMDs.

Medicaid funds also can become available for IMDs through savings that states generate from Medicaid managed care programs and through the use of Medicaid waivers that allow the states to add optional services or populations if they offset the additional costs by Medicaid savings. Those sources of funds are threatened by the state-budget crises that have led to cuts in Medicaid enrollees and benefits.

"The role of public psychiatric hospitals is changing constantly," concluded the report's executive summary. "States have worked since the 1950s to move large numbers of patients out of these facilities into community-based treatment settings. The challenges faced by state and county psychiatric hospitals are substantial and are likely to affect future Medicaid financing strategies pursued by the hospitals themselves or on their behalf."

"Medicaid Financing of State and County Psychiatric Hospitals" is posted on the Web at <www.mentalhealth.org/publications/allpubs/SMA03-3830/default.asp>. ■

Generally, It's Impossible To Generalize About MH Benefits

New reports from the Substance Abuse and Mental Health Services Administration provide an overview of "medical necessity" and mental health services for privately insured patients.

BY MARK MORAN

Definitions of "medical necessity" vary widely from health plan to health plan and are liable to encompass multiple factors and considerations—only one of which is a clinician's professional judgment.

And since they are written into proprietary contracts with payers, definitions of medical necessity are rarely available to the public or to clinicians.

Those were among the findings of a report by the Substance Abuse and Mental Health Services Administration (SAMHSA) released last month. The report, "Medical Necessity in Private Health Plans: Implications for Behavioral Health Care," relied on peer-reviewed medical and health services literature, expert opinion, and state-level investigations and legal settlements regarding medical necessity practices, among other sources.

The study was accompanied by two other reports, also by SAMHSA, on mental health services in managed care, and on Medicaid financing of psychiatric hospitals (see story above). Together, the three government reports provide an overview of mental health care in the public and private sectors.

The report on mental health services, titled "The Provision of Mental Health Services in Managed Care Organizations," provides an overview of the private health insurance market and how patients receive mental health services in managed care plans.

The primary source for the report is the 1999 Brandeis University Survey on Alcohol, Drug Abuse, and Mental Health Services in Managed Care Organizations, funded by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. The survey collected information from 434 managed care organizations in 60 market areas and was supplemented with additional data analysis and case studies on mental health services from SAMHSA.

Among that report's findings are the following:

- HMOs are most likely to report using specialty contracts ("carveouts") with managed behavioral health care organizations (MBHOs).
- About half of products [health care plans] with specialty contracts place the MBHO at some risk if claims costs exceed targeted amounts.
- HMOs are more likely than preferred provider organizations to include performance standards in their contracts.
- A majority of products have annual limits on outpatient mental health visits and on inpatient days, and cost sharing for outpatient visits is notably higher for mental health than for general medical care.
- About half of all products distribute practice guidelines for selected mental health disorders to primary care providers.

The medical necessity report underscores a fact that has been absorbed by many clinicians in the two decades since the advent of managed care, but may still run counter to intuition: criteria for medical necessity are not based solely—or even primarily—on clinicians' professional judgment.

"What psychiatrists and health care practitioners in general should understand is that insurers are making decisions about medical necessity on the basis of multiple dimensions," said co-author Brian Kamoie, J.D., M.P.H. "Professional judgment is still very important, but it isn't the only dimension."

The most important factor is one that might seem to be obvious enough: whether a service is covered by the contract.

"The primary determinant is the scope of the contract," Kamoie said. "Whether or not an insurance contract provides any coverage for the service being rendered by a physician takes primacy in the sense that if the contract does not cover a service, it won't be paid. This has nothing to do with clinical need for the service."

Contractual scope is just one of five factors that typically go into definitions of medical necessity. These are the others:

- Standards of practice—whether the treatment accords with professional standards of practice.
- Patient safety and setting—whether the treatment will be delivered in the safest and and least-intrusive manner.
- Medical service—whether the treatment is considered medical as opposed to social or nonmedical.
- Cost—whether the insurer considers the treatment cost-effective.

Regulation of medical necessity criteria is rare and not uniform. The SAMHSA report cited 17 states that have definitions, ranging from the broad to the very specific. Accordingly, there are wide differences from health plan to health plan in how medical necessity is defined, Kamoie said.

"They are highly variable," he told *Psychiatric News*. "And they are difficult to access because they are typically contained in private contracts, which are usually considered proprietary. Often they are unearthed through litigation."

Where there is regulation, and liable to be more, is in the area of appeals, Kamoie said. According to the report, 40 states and the District of Columbia had by 2002 enacted external review laws that allow enrollees to appeal health plan decisions to deny, reduce, or terminate care to an independent review organization (IRO). Nearly half of these states have drafted regulations pursuant to statutes established by the IRO.

Kamoie said health plan definitions of medical necessity have evolved in the period since the advent of managed care as health plans have changed the way they review claims.

"It used to be that review was retrospective, after the service was provided," Kamoie said. "As cost containment became a concern, the industry moved to prospective decision making. That's where the use of medical necessity has evolved."

Despite the fact that medical necessity criteria are often not publicly available, Kamoie said that he hopes the findings from the SAMHSA report will inform clinicians in their interactions with patients and with health plans. "Armed with the information that this process is going and that it typically involves the five dimensions outlined in the report, physicians should be able to start asking questions," he said.

"Medical Necessity in Private Health Plans: Implications for Behavioral Health Care" is posted on the Web at <www.mentalhealth.org/publications/allpubs/SMA03-3790/default.asp>. This report and "The Provision of Mental Health Services in Managed Care Organizations" are also available from SAMHSA's National Mental Health Information Center at (800) 789-2647. ■

Models Point Way to Integrate Mental Health, Primary Care

Physicians, administrators, and government agencies have worked together to develop models to integrate mental health services and primary care, but implementation lags behind.

BY KATE MULLIGAN

David Pollack, M.D., and other Oregon state employees are using the state's budget crisis to propel efforts to integrate mental health and primary care services.

Pollack, medical director of the Oregon Office of Mental Health and Addiction Services, told attendees at the annual meeting of the National Academy for State Health Policy in Portland that cutbacks in mental health coverage for people on the Oregon Health Plan (OHP) added urgency to the need for enhanced mental health services within primary care settings.

On March 1 the state cut outpatient mental health and substance abuse treatment benefits for 100,000 state residents who are eligible for the OHP but who do not meet criteria for mandatory Medicaid coverage.

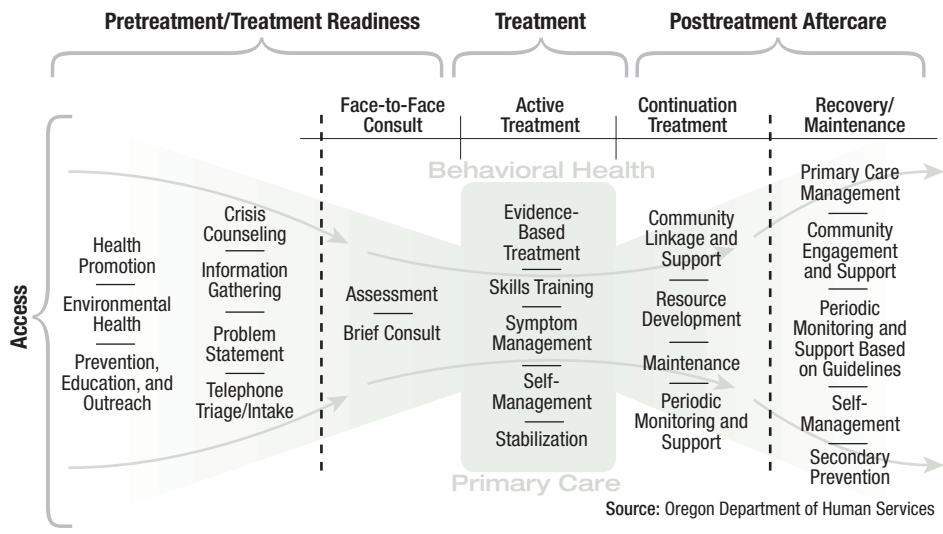
He described the three models or approaches for integrating mental and primary health care, which the state is combining to produce a fourth model.

The Four Quadrant Model, which was developed by the National Council for Community Behavioral Healthcare, clarifies the roles and location of treatment, depending on the degree of severity of symptoms and of comorbidity.

Patients with low complexity and risk for both "physical" and mental health conditions, for example, are in quadrant one. They typically can receive mental health services in the primary care setting. In quadrant four are patients with high complexity for both "physical" and mental health conditions. They require the most specialized and comprehensive services.

The Pathway to Care Model helps convey the range of treatment types and shows the similarities between the continuum of mental health and primary care services (see diagram).

Pathway to Care



Source: Oregon Department of Human Services

The model can be used to identify access, efficiency, and cost issues by highlighting gaps in the continuum. It calls attention to the importance of such activities as health promotion, crisis counseling, and community supports that are not always acknowledged in integration models.

The Chronic Care Model emphasizes the importance of an informed patient who knows about and can use strategies to manage his or her illness. Health care administrators organize resources to provide that support.

Care is delivered by a team of clinicians who work together to provide evidence-based treatment that includes an educational component for the patient and family members.

Successful implementation of any model or combination of models varies according to conditions at the local level, but it requires the completion of key tasks, said Pollack.

Administrators must complete an "environmental scan" to assess the pertinent resources and obstacles and gain "buy-ins" from administrative and clinical leaders whose support will be necessary.

They must make decisions about issues such as whether to contract for mental health services or employ mental health personnel directly.

Pollack told the group that both the federal government and foundations are promoting and funding activities that encourage integration of care.

He said, "The Health Disparities Collaboratives [HDC] project is one of the most exciting health care improvement programs going on anywhere."

The HDC, which is funded by the Bureau of Primary Health Care at the Department of Health and Human Services, was developed to reduce disparities in health outcomes for poor, minority, and other underserved people by improving primary care practices.

It operates through community health centers to encourage collaboration on treatment for diabetes, asthma, cardiovascular disease, and depression and has developed training programs and other resources that are available at its Web site, <www.healthdisparities.net>.

The John D. and Catherine T. MacArthur Foundation is supporting the Initiative on Depression and Primary Care, with the aim of improving the quality of care for patients who have depression and are seen in primary care settings.

Information on the initiative is posted on the Web at <www.macfound.org/research/hcd/mhp/depression_primary_care.htm>. The Four Quadrant Model Background Paper is posted at <www.nccbh.org>. Information on the Chronic Care Model is posted at <www.improvingchroniccare.org>. The American Association of Community Psychiatrists' position paper on mental health and primary care integration is posted at <www.wpic.pitt.edu/aacp/finds/PCPMenu.html>. ■

Bill Seeks to Reverse Trend Of Parents Ceding Custody

Legislation to be introduced shortly In the House of Representatives will give parents more options for obtaining treatment for their mentally ill children than relinquishing custody.

BY CHRISTINE LEHMANN

A new bill in Congress will alleviate some of the pressure on parents to relinquish custody of children to obtain necessary mental health services. Sens. Susan Collins (R-Maine) and David Pryor (D-Ark.) and Reps. Patrick Kennedy (D-R.I.) and Fortney "Pete" Stark (D-Calif.) plan to introduce the Keeping Families Together Act this month.

The bill calls for establishing a six-year, $55 million federal-matching grant program for states to create a coordinated system of services and supports for children with serious mental or emotional disorders.

States could use these funds to expand public health insurance to cover mental health treatment for eligible children and families; provide outreach and public education programs and training and professional development for personnel working with children with mental illness; help the state develop a system to track children who enter the child welfare system solely to obtain mental health treatment; and provide individualized services for children and their families, according to a press statement from Collins's office.

Collins, chair of the Senate Government Affairs Committee, held two days of hearings in July on the reasons parents give up custody of their children with mental illnesses (*Psychiatric News*, August 15). Recommendations by mental health advocates and officials from the General Accounting Office (GAO) who testified at the hearings were incorporated into the legislation. Collins, Stark, and Kennedy commissioned a GAO report earlier in the year on the reasons for parental relinquishment of custody (*Psychiatric News*, June 6).

Reps. Patrick Kennedy (D-R.I., right) and Fortney "Pete" Stark (D-Calif.) plan to introduce legislation this month in the House of Representatives (HR 953) to address the problem of parents relinquishing custody to obtain mental health services.

States Need More Resources

Mental health advocates recommended that Congress provide states with additional resources and guidance to implement home- and community-based services for children with mental disorders.

Tammy Seltzer, a staff attorney at the Bazelon Center for Mental Health Law in Washington, D.C., told the committee, "The single, most important obstacle that pushes families into giving up custody of children is a lack of access to appropriate and timely mental health services and supports for children in the public and private sectors."

States Ban Custody Relinquishment

Trina Osher, coordinator of policy and research for the Federation of Families for Children's Mental Health, testified that "the practice of states requiring parents to relinquish custody to obtain essential mental health services for their children must cease. However, a ban needs to be combined with providing increased access to mental health services for children."

Thirteen states have already banned parental-custody relinquishment solely to obtain mental health services for children, according to Stark, who testified at the hearing along with Kennedy. The federal legislation does not require states to ban child-custody relinquishment, but says that federal matching funds will help states eliminate the practice.

Families with private health insurance quickly exhaust their mental health benefits due to a lack of insurance parity, said Osher.

She and Seltzer urged Congress to pass the Senator Paul Wellstone Mental Health Parity Act cosponsored by Kennedy in the House and Collins in the Senate. The bills (HR 593, S 486) would require private health insurance plans with mental health benefits to provide the same number of inpatient days, outpatient visits, and copayment and deductible amounts as provided for other health care benefits.

"Most children return home from hospitals or residential treatment programs without any follow-up services or supports, simply because they have reached the maximum number of days for which insurance will pay. Typically, these children were not stabilized in the first place, and no links to school and community-based mental health services and home-based supports were made on discharge," said Osher.

please see ***Custody*** *on page 33*

Family Suicide Leads Student To Open Minds on Campus

The suicide of a vibrant college student gives rise to a new student-run mental health awareness program that encourages students to discuss mental health issues and seek help when they need it.

BY EVE BENDER

Brian Malmon was the quintessential big brother. Perhaps it was a combination of his sharp wit, dry humor, intelligence, and "laid back" demeanor that made him the apple of his younger sister's eye.

As a high school student in Maryland, he was a sports reporter for the community newspaper, and as an undergraduate at Columbia University, he was president of his a cappella group Uptown Vocal and sports editor of Columbia's newspaper. He was an avid fan of the TV show "The Simpsons" and the music of the Red Hot Chili Peppers. He starred in a theatrical production one year and managed to stay on the dean's list most of the time—all despite the fact that in his freshman year, he had begun to experience symptoms of schizoaffective disorder.

"He kept his illness a complete secret until his senior year," his younger sister Alison told *Psychiatric News*.

Brian took a leave of absence in 1998 and returned to Maryland to receive treatment, which included a number of different combinations of medicines and intensive therapy. "He essentially tried everything possible at some point during the year and a half that he was home," Malmon said. Some of the medicines didn't seem to have much effect on her brother's illness, she said, while others started working but then stopped.

In March 2000 Brian committed suicide at home. "Brian and I had been through a lot together, including our parents' divorce," Malmon said. "We were the only ones who could truly understand one another in many respects. When he died, I felt like I lost my other half."

At the time, Malmon was a student at the University of Pennsylvania. "As a freshman, I reflected on the culture surrounding mental illness at Penn and realized no one was talking about mental health issues," Malmon said.

To raise awareness about mental illness and provide her fellow students with information about where to go for help, she founded a student-run organization, Open Minds, in 2001. "My motivation for starting the group was the two and a half years my brother spent at school, sick and isolated," she said.

With the support of the university's administration and Counseling and Psychological Services office, she began recruiting members and developed a mission statement.

Administration Provides Seed Money

Malmon even received a $10,000 grant from the university administration to sponsor activities, including seminars with guest speakers such as Ross Szabo, a mental health advocate who talks to young audiences about his experiences with bipolar disorder; panel discussions on mental health issues; and an annual race on campus in which the runners are clad in T-shirts listing various facts about mental illness in adolescents.

The group also hosted an event at a fraternity on campus at which bands played and vendors donated refreshments. Students paid a nominal fee for the evening's entertainment, and the proceeds went to the adolescent unit of a local psychiatric hospital, Malmon said.

The group also distributes flyers on campus, including one listing famous people with mental illness and another with symptoms and prevalence rates of a number of mental illnesses. There are also brochures with information about Open Minds listing contact information for the Counseling and Psychological Services on campus, which, Malmon said, tends to be understaffed and overburdened. "We do their outreach," she said.

Students React Positively

Student reaction to Open Minds has been positive, Malmon said, and events have been well attended. During certain events, Malmon said she shares the story of her brother's suicide with her peers. "If I'm trying to destigmatize mental illness, I can't keep anything secret," she explained. The

Alison Malmon accepts the Tipper Gore Remember the Children Award at the annual meeting of the National Mental Health Association. The award honors a person who has shown outstanding commitment to children's mental health issues.

students, she said, respond with gratitude and some with their own disclosures about mental illness in their families.

Malmon graduated from Penn in May and now serves as a consultant to the students running the program. In addition, she is looking for ways to bring Open Minds to other colleges and universities.

Last year, Katie Hard, a close high school friend of Malmon's, started a chapter of Open Minds at Georgetown University in Washington, D.C., where she is a senior. The group sponsors activities similar to those at Penn to "create conversation around the topic of mental illness" and direct people to help resources, she explained.

Before Open Minds began reaching out to Georgetown students, Hard said, some students in need of mental health services didn't know that Georgetown's counseling center even existed. Leaders of the student-run organization, she added, are approached by friends or roommates of people who are experiencing the symptoms of mental illness and "don't know what to do, who to talk to, or where to go—we direct them."

Hard said she has received administrative support from the Health Education Services and School of Nursing and Health Studies, which has funded some activities on campus.

"When Alison's brother committed suicide, it really affected our group of friends," Hard said. "If we can help just one student on campus, all the better."

Anthony Rostain, M.D., director of education at the University of Pennsylvania's department of psychiatry and an associate professor of psychiatry and pediatrics, worked with Malmon when he chaired the university's Mental Health Outreach Task Force.

The university's provost convened the group during the 2001-02 academic year after three student suicides in order to assess the state of mental health outreach efforts and resources available to students.

Rostain also advised Malmon on her senior thesis project, in which she surveyed 100 Penn students on their knowledge and attitudes surrounding mental illness.

He described Malmon as a "talented student leader who has been able to mobilize a creative group of students to address issues of mental health and destigmatize mental illness in a dynamic way."

The university's administration and faculty, he added, have been appreciative of the group's accomplishments. "We feel the group's presence on campus has made it easier to get the message across to students that asking for help is not a sign of weakness and that mental disorders are as real as physical disorders," he said.

More information about Open Minds is posted on the Web at <http://dolphin.upenn.edu/~openmind>. ■

Depressed Parents Will Be Focus Of Depression Screening Day

This year's National Depression Screening Day, which will be held on October 9, will focus on screening parents for depression and encouraging those with depression to speak openly with their children about the illness and its treatment.

BY EVE BENDER

Screening and treatment for depression in parents is a new focal point for this year's National Depression Screening Day (NDSD). The campaign is titled "Can a Depressed Parent be a Good Parent? You Bet!"

Screening for Mental Health Inc., a nonprofit agency based in Massachusetts, has organized NDSD each year since 1991.

The event is held at 6,000 screening sites throughout the United States and Canada, and its goal is to help to identify people with mood disorders, such as depression and bipolar disorder, generalized anxiety disorder, and posttraumatic stress disorder; educate the public about psychiatric illnesses; and combat the stigma surrounding them.

This year's NDSD will take place on October 9, and as part of the new campaign, a new brochure will be distributed to NDSD screening sites urging parents to seek help for depression and talk openly with their children about depression and treatment. The brochure also advises parents with depression to make sure that their children don't blame themselves for the depression and to explain that they are seeking treatment in order to get better.

The campaign and brochure are based on an intervention developed by William Beardslee, M.D., psychiatrist in chief at Children's Hospital in Boston and the Gardner Monks professor of psychiatry at Harvard Medical School, as described in his book, *Out of the Darkened Room: When a Parent Is Depressed—Protecting the Children and Strengthening the Family.*

It is not uncommon, he added, for many parents with depression to be self-critical and worry that their children will be adversely affected by their depression.

He suggested that parents speak openly about depression and treatment with children to increase their understanding about the illness and "build resilience in children by encouraging them to be involved in friendships and activities outside the home."

Said Douglas Jacobs, M.D., the founder and executive director of Screening for Mental Health Inc., "Our message is that by seeking treatment, parents can feel better themselves and help their whole family . . . . This will resonate with a lot of people, and NDSD has always been about finding a way to connect people with available services."

Those interested in providing screening on National Depression Screening Day must register by downloading a form at the Web site <www.mentalhealthscreening.org> or by calling (718) 239-0071. Registration fees are $150 for most private sites, $50 for public-sector sites, and free for primary care screening sites. ■

Victimization Called Leading Cause Of Adolescent Violence

Two major reasons for adolescent violence appear to be having been victimized by violence oneself and illicit drug use.

BY JOAN AREHART-TREICHEL

While statistics show that the United States has a serious problem with violence, Colombia has an even more severe plague of violence.

Thus, David Brook, M.D., an addiction psychiatrist by training and a professor of community and preventive medicine at Mount Sinai School of Medicine in New York, along with American and Colombian colleagues, decided that Colombia would be the appropriate setting for exploring the causes of adolescent violence.

What they have found is that the prime cause of adolescent violence appears to be having been victimized by violence oneself. The second major contributor is illicit drug use.

Their results were reported in the August *American Journal of Psychiatry*.

Brook and his coworkers decided to focus their investigation on three Colombian cities—Bogota, Medellin, and Barranquilla. Bogota was chosen because it has a population that is diverse in socioeconomic status, has large concentrations of adolescents living in communities at various levels of urbanization, and has one of the highest rates of homicide in Colombia. Medellin was selected because it is the second-largest city in Colombia, is a major commercial and industrial center and has one of the highest homicide rates in the world. Barranquilla was picked because it is one of Colombia's largest cities, yet has a much lower homicide rate than the other two. Illicit drug use is prevalent in all three cities.

Brook and his team randomly selected adolescents from census data and asked them to participate. Free American sports apparel and the opportunity to be part of a scientific study were used as inducements. Eighty percent of these teens—about 2,800 out of 3,500—agreed to sign on. About half were male.

The investigators then administered a structured two-hour questionnaire that had been previously used to study adolescent violence in the United States. It asked questions having to do with a teen's personality and behavior, family, peers, availability of illicit drugs in the community, prevalence of violence in the community, and whether he or she had engaged in various types of violent behaviors. The researchers made sure that all of the questions were relevant to Colombian culture and that the questions were translated correctly into Spanish.

The questionnaire was then administered to each subject in his or her home, in private if possible, by a Colombian interviewer. To maintain confidentiality, questionnaire answers were identified only with a code number.

Fighting Is Common

The scientists then analyzed their questionnaire findings to see what percentages of their subjects had engaged in violent behaviors. They found, for example, that some 48 percent had been in a serious fight at least once, 14 percent had held a weapon against someone at least once, 7 percent had cut someone with a knife at least once, and 6 percent had shot someone at least once.

Taking variables such as age, gender, ethnicity, and socioeconomic background into consideration, the scientists attempted to see whether there were any biopsychosocial factors that set apart the subjects who had engaged in violent behaviors from those who had not.

The answer was yes, they found. A number of factors were associated with adolescent violence to a statistically significant degree. These were a tolerance for deviance, lack of sensitivity, illicit drug use, father or sibling who used illicit drugs, parent-child conflict, tolerance of deviance in peers, use of illicit drugs by peers, drug availability, watching violence on television, and having been victimized by violence oneself. In fact, having been victimized by violence emerged as the leading cause of adolescent violence; using illicit drugs came in second.

The study also found that each of the above risk factors for adolescent violence remained a danger even when a teen possessed some other qualities that often protect against such violence. For example, family risk factors for violent behavior predisposed a teen to commit a violent act even when the teen did not have a violence-prone personality or lived in an area with little brutality.

Studies of adolescent violence in the United States have also identified some of the same risk factors that this study did. For example, one investigation found that beyond engaging in delinquent behavior, being a victim of violence is the most powerful predictor of adolescent violent behavior.

Thus, "our research suggests that key risk factors for violent behavior in adolescents are common to Colombia and the United States," Brook and his team concluded.

Indeed, "there might be universal risk factors for violence," Brook ventured during an interview with *Psychiatric News*, "based not only on this study but on others that we have done elsewhere, including the United States."

Are There Protective Factors?

In contrast, if there are universal risk factors for violence, there may be universal factors that protect against it, too, Brook noted. For instance, this investigation yielded one finding that surprised him—whereas more than half of the youngsters who took part in the study had been victimized by violence at some point, only one-third of them went on to perpetuate violence themselves. "So being a victim does not necessarily mean that you will engage in violence," Brook asserted. "There is a gap there that maybe can be worked with."

The study was financed by the National Institute on Drug Abuse.

The study, "Early Risk Factors for Violence in Colombian Adolescents," is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/160/8/1470?>. ■

9/11 Didn't Cause Upsurge In VA Mental Health Services

Use of mental health services by veterans was not affected by the traumatic events of September 11, a new study reveals.

BY JIM ROSACK

Two years ago, following the terrorist attacks of September 11, community surveys indicated significant psychological distress that led some mental health experts to predict widespread increases in the need for mental health services. Indeed, early reports indicated an increase in need for mental health services, resulting in massive efforts—such as the $100 million-plus Project Liberty, funded by the Federal Emergency Management Agency and the Center for Mental Health Services—to provide screening, referral, and counseling services *(Psychiatric News*, September 6, 2002). Experts predicted that veterans who had pre-existing posttraumatic stress disorder (PTSD) would be especially vulnerable to the traumatic events of that day and the war on terrorism that would follow.

Now, a new study appearing in this month's *American Journal of Psychiatry* has determined that those predictions were not fulfilled. The data indicate that the terrorist attacks of September 11 resulted in no significant increase in the use of Veterans Affairs services for the treatment of PTSD or other mental disorders or in visits to psychiatric or nonpsychiatric clinics in New York City, the greater New York metropolitan area, or Washington D.C.

"There have now been a number of studies—of which ours is only one—that have shown that, in fact, the increase in [the use of] mental health services and of medications was far less than previously reported and did not last very long," said Robert Rosenheck, M.D., director of the Department of Veterans Affairs Northeast Program Evaluation Center (NPEC) in West Haven, Conn., and a professor of psychiatry at Yale University.

Rosenheck and his co-author, Alan Fontana, Ph.D., also at the NPEC and a research scientist in the department of psychiatry at Yale, analyzed national administrative data from the VA's health care system to compare use of both mental health and general medical services during the six months before and after September 11, 2001. They then compared those usage patterns to data from the same periods surrounding September 11 in 1999 and 2000.

"The main limitation on this study was we were looking at administrative data—we didn't have any data on symptom reactions," Rosenheck told *Psychiatric News*. "We have a subsequent study that does address the symptom picture, and in analyzing those data we actually found that in the period after September 11 [2001] veterans coming into [the VA's specialized PTSD treatment] programs had lower—slightly lower—symptom levels than veterans in previous years and that, remarkably, they showed more improvement."

Taken together, Rosenheck said, the data indicate that "there was a great deal of coming together as a nation after September 11. Secondly, there was a good deal of honor paid to veterans—they were given great respect after that, and there was also a widespread recognition that PTSD was a serious problem that people who had been exposed to traumatic conditions could have."

All of these phenomena, Rosenheck believes, helped to make veterans feel especially supported and validated. As such, they appear to have been less vulnerable, rather than more vulnerable, in spite of their prior experiences.

What people experienced following September 11, 2001, Rosenheck emphasized, "were extraordinary reactions to extraordinary events. What they were not is mental illness."

What is fascinating, he added, is that in American culture, "if something really awful happens, one of the ways we try to communicate to each other the horror of it is by saying that it causes mental illness." But there is a great deal of horror in the world that does not lead to mental illness, Rosenheck noted.

"It is important for us as psychiatrists," Rosenheck commented, "both to identify mental illness when it is underrecognized, but also to identify things that are emotionally upsetting, yet not necessarily mental illness."

"Use of Mental Health Services by Veterans With PTSD After the Terrorist Attacks of September 11" is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/160/9/1684>. ■

Association News

New Discount For MITs!

In response to the very popular Sunrise Special Sale at APA's annual meeting for members-in-training (MITs), American Psychiatric Publishing Inc. (APPI) is now extending those sale prices year-round. Thus, MITs are now eligible to receive a 25 percent discount when they purchase books and journals from the APPI Web site at <www.appi.org>. When ordering, they should use PRIORITY CODE "APAWEB3."

Medication Studies Increase For Children, Adolescents

The FDA's pediatric exclusivity program spurs significant research of adult medications in pediatric populations, resulting in some intriguing data.

BY JIM ROSACK

As the body of efficacy evidence continues to grow, clinical trials of adult medications in children are adding strength to a long-held scientific secret: Children are not simply adults hiding in a smaller package, at least not when it comes to medications.

In 1997 the Food and Drug Administration Modernization Act (FDAMA) required the agency to promote research into pediatric use of adult medications through a "pediatric exclusivity" incentive program.

The program promised drug manufacturers an additional six months of patent protection for their branded medications in exchange for research on the use of those medications in children.

The FDAMA instructed the FDA to develop a list of medications approved for use in adults that were commonly used in children but had not been studied for safety or efficacy in pediatric populations. From that list, the FDA was to make written requests to the manufacturers of the drugs on the list asking for clinical data on at least the safety of the medications in children and adolescents. Efficacy studies were not required.

According to information posted on the FDA Web site, as of August 22, 88 medications had been studied in children, resulting in labeling changes to 58 and the granting of pediatric exclusivity to 53. To date, the FDA has issued 242 written requests for pediatric data.

While the FDA requested pediatric data on numerous psychotropic and related medications, only two antidepressant, one antiseizure, and two antianxiety medications have undergone pediatric labeling changes.

In 1998 midazolam (Versed) was relabeled to include data on effective dosing and time of onset and adverse-event information specific to pediatric populations. In 2000, fluvoxamine (Luvox) was relabeled to reflect data on dosing and the requirement for a dose adjustment in adolescents (increased dose) and girls aged 8 to 11 (decreased dose). Also that year, gabapentin (Neurontin) was relabeled to reflect neuropsychiatric adverse events in children aged 3 to 12.

Late in 2000, Lilly submitted data showing fluoxetine's safety and efficacy in children and adolescents for both obsessive-compulsive disorder and major depression. To date, it remains the only antidepressant labeled as indicated for children and adolescents (see related article on page 2). The fluoxetine studies documented decreased weight gain in children and the potential for switching of children into mania or hypomania. Specific dosing information was also included in the revised label.

Recently, studies of paroxetine (Paxil) created a stir when they failed to show efficacy in children and adolescents with major depression and raised significant safety concerns about suicidal thoughts and behaviors in pediatric populations. Those studies were prompted by the pediatric exclusivity provision.

In 2001 Bristol-Myers Squibb submitted data showing that the safety and efficacy of buspirone (Buspar) were not shown in patients aged 6 to 17 for generalized anxiety disorder. In addition, the studies found variable pharmacodynamic parameters that differed from those in adults. In many cases, including those above, studies prompted by the pediatric exclusivity clause of FDAMA (which was reauthorized by Congress in 2002) have found significant differences in the use of the medication in children and adolescents compared with adults.

A study in the August 20 *Journal of the American Medical Association* highlights those differences. The study, by four staff members of the FDA's Office of Counter-Terrorism and Pediatric Drug Development, concluded that the FDAMA "has stimulated pediatric clinical studies, resulting in improved understanding of the pharmacokinetics of drugs prescribed in pediatric medicine, important dose changes, and improved safety for children taking certain drugs."

Dianne Murphy, M.D., director of the FDA's Office of Pediatric Therapeutics and a co-author of the report, noted in a press release that while the pediatric exclusivity program "has led to improvements, it is voluntary and cannot solve the problem alone."

Indeed, the FDA has supported the Pediatric Research Equity Act (S 650), which was passed by the Senate and awaits action by the House of Representatives. The bill would restore a 1998 FDA regulation known as the pediatric rule under which the FDA could require drug companies to undertake clinical trials of medications in pediatric populations and submit data on safety and efficacy.

The pediatric rule was struck down by a U.S. District Court decision in October 2002. The court ruled that the FDA did not have legislative authority from Congress to require pediatric testing. S 650, which would give the agency that authority, has been supported by APA, the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and AMA.

Murphy's study is posted on the Web at <http://jama.ama-assn.org/cgi/content/full/290/8/1033>. The text of the Pediatric Research Equity Act can be accessed at <http://thomas.loc.gov> by searching on the bill number, S 650. ■

Children

continued from page 2

placebo (30.24 points vs. 25.83 points, respectively, at week 10). With "response" prospectively defined as a 40 percent reduction in the adjusted CDRS–R score by the end of the studies, 69 percent of those taking sertraline were classified as responders, compared with 59 percent of patients taking placebo.

Seventeen patients taking sertraline (9 percent) dropped out of the studies because of adverse events, compared with five patients taking placebo (3 percent). Within the overall study population, adverse events were defined as those that occurred in at least 5 percent of patients taking sertraline and with a rate at least twice that of patients taking placebo. In children (aged 6 to 11), reported events included insomnia (19.8 percent), diarrhea (15.1 percent), anorexia (10.5 percent), vomiting (9.3 percent), agitation (8.1 percent), and urinary incontinence (5.8 percent). Among adolescents (aged 12 to 18) events included vomiting (7.8 percent) and diarrhea (6.8 percent).

Seven patients taking sertraline experienced a serious adverse event (as defined by the FDA) compared with six patients taking placebo. Serious events included suicide attempt (two patients taking sertraline and two taking placebo), suicidal ideation (three sertraline, no placebo), and aggressive reaction (one sertraline, no placebo).

Patients taking sertraline lost an average of 0.8 pounds through the 10-week studies, compared with a gain of 1.7 pounds for patients taking placebo.

Clinical Significance

Wagner and her colleagues note that "the significance of the results is clinically as well as statistically relevant."

With only three previous studies showing any benefit of SSRIs for pediatric depression, and no studies showing a benefit for tricyclic antidepressants, the current study's treatment effect is "modest in comparison with that typically observed in adult studies," according to the authors.

But in pediatrics, only one study—with fluoxetine—has shown a more robust effect with an antidepressant. That study, however, involved a significantly smaller group of children and adolescents.

Wagner and colleagues believe that one problem is the large placebo effect often seen in children. "Data suggest that the placebo response rate is at least as high in [the pediatric] age population [as it is in adults]," the authors noted. "Increased visit frequency and the attention associated with these visits may have an intrinsic component of therapy and is different from a 'waiting period' control, in which there is no interaction."

Studies Should Be Expanded

The authors noted that while this study suggested that sertraline was slightly more effective, as well as more tolerable, in adolescents than in children, further studies need to be completed to determine whether that is true in the general population. They also noted that discontinuation of sertraline was not associated in these studies with a "withdrawal syndrome" like that often observed in patients taking paroxetine and venlafaxine.

"Nonetheless," the authors concluded, "the results reported here support the conclusion that sertraline is an effective, safe, and well-tolerated short-term treatment."

An abstract of the article is posted on the Web at <http://jama.ama-assn.org/cgi/content/full/290/8/1033>. ■

Impulsiveness Key Feature Of Kleptomania

What drives some people to engage in kleptomania? Maybe anxiety and depression. Perhaps sensation-seeking. And most certainly impulsivity, a new study suggests.

BY JOAN AREHART-TREICHEL

All that has been known about kleptomania has come primarily from isolated case reports or studies of a small number of cases. After all, the condition is probably rare, and those who have it may be reluctant to seek treatment since their behavior is illegal.

Now, however, some French and Lebanese researchers have not only studied a handful of kleptomania subjects, but have compared them with subjects with some other kinds of disorders to gain a better understanding of the disorder.

And as the investigators reported in the August *American Journal of Psychiatry*, individuals who engage in pathological stealing do not seem to be driven by obsessions or compulsions or by a need to abuse substances, as some have theorized. They may, however, be motivated by anxiety and depression or by sensation-seeking, and especially by impulsivity. Impulsivity is "the major psychopathological feature of kleptomania," they asserted in their report.

Franck Bayle, M.D., of the Centre Hospitalier Sainte-Anne in Paris and his colleagues recruited 10 individuals with kleptomania over a two-year period. To serve as comparison subjects, researchers also recruited 29 psychiatric patients without any impulsive-control disorder or substance-related disorder and 60 patients with alcohol abuse or dependence .

The researchers noted that most of the kleptomania subjects were women; the average age of onset of kleptomania had been age 30, with an average duration of illness of six years; all subjects had reached a university academic level.

Neurological examinations were normal. Only one of the subjects had had obsessive-compulsive disorder or tics, and only one had an alcohol-abuse problem. However, a number had mood disorders, other impulse-control disorders (for example, trichotillomania), and/or substance abuse or dependence (mainly nicotine addiction).

The onset of kleptomania varied for the subjects. It started one year after the onset of bulimia for two; several years after the

please see ***Kleptomania*** *on page 30*

Child Maltreatment Appears Epidemic in U.S.

Forty-three percent of American children are mistreated in some manner, a large new community study suggests, and a third of them experience more than one kind of abuse.

BY JOAN AREHART-TREICHEL

America may be the "land of the free and the home of the brave," as the old saying goes, but it may also be the land of widespread child maltreatment.

So suggests a new study conducted not just on a large community sample, but on people who were largely well educated and well off financially. If the study had been conducted on an even more diverse community population, child mishandling may well have been found to be even more prevalent.

The study was headed by Valerie Edwards, Ph.D., of the Centers for Disease Control and Prevention in Atlanta. The results appeared in the August *American Journal of Psychiatry*.

A decade ago, an investigation called the Adverse Childhood Experiences Study was launched at a large city health maintenance organization (HMO) to examine the associations between childhood maltreatment, family dysfunction, and adult health outcomes. Almost 13,500 HMO members first underwent a physical exam for the study. Of these, about 8,500 filled out a 162-item family health history questionnaire that included questions about childhood maltreatment and exposure to family dysfunction, as well as current health behaviors and conditions.

Childhood sexual abuse was assessed with four questions adapted from a questionnaire that covered fondling, attempted intercourse, and intercourse. Respondents who gave an affirmative answer to any of the four items were classified as sexually abused.

Childhood physical abuse was assessed with two items adapted from the Conflict Tactics Scale. Respondents who indicated that they had been pushed, grabbed, shoved, slapped, or had something thrown at them "often" or "very often" or who indicated that they had been hit so hard that they had marks or were injured "once" or "more than once" were considered victims of childhood physical abuse.

Being a witness of maternal battering was assessed with four items adapted from the Conflict Tactics Scale relating to having seen their mother being pushed, grabbed, or slapped or having something thrown at her.

The intensity of emotional abuse in the childhood family environment was assessed with the emotional abuse subscale of the short form of the Childhood Trauma Questionnaire.

Women made up a little more than half of the questionnaire respondents. Almost three-fourths of the respondents were white, 11 percent Hispanic, 8 percent Asian, and 4 percent African American. More than three-fourths of the respondents had some college education. Of the 8,500 HMO members who filled out the family health history questionnaire, some 7,500 also completed the Medical Outcomes Study 36-item Short-Form Health Survey to assess their current mental health status.

Now, Edwards and her coworkers have tapped questionnaire and survey responses from these some 7,500 subjects to answer three questions: How many had been maltreated as children, whether those who had been mishandled had experienced more than one kind of mishandling, and whether there was a dose response between being handled improperly as a child and one's adult mental health status.

A disturbingly large number of the 7,500 subjects—43 percent—reported having been maltreated in the areas under study: physical abuse, sexual abuse, and/or witnessing maternal battering, the researchers found. Specifically, 22 percent reported having been sexually abused, 21 percent reported having been physically abused, and 14 percent reported having witnessed maternal battering. And while more women than men reported having been sexually abused (25 percent versus 18 percent), more men than women reported having been physically abused (22 percent versus 20 percent).

The investigators also made the troubling discovery that more than one-third of the 43 percent of respondents reported having been maltreated in more than one manner as a child. For example, of the 25 percent of women who reported having been sexually abused, more than half (14 percent) also reported having experienced at least one additional form of abuse. Similarly, of the 22 percent of men who had reported having been physically abused, about half (11 percent) also reported having been sexually abused, witnessing maternal battering, or both.

The researchers also looked to see whether having been maltreated as a child had a negative impact on adult mental health in a dose-response manner. The answer was essentially yes, they found. For instance, 7 percent of men who reported having witnessed maternal battering, 10 percent who reported having witnessed maternal battering plus having been physically or sexually abused, and 16 percent who reported having witnessed maternal battering plus having been physically and sexually abused had a low mental health score as an adult. Similarly, 14 percent of women who reported having witnessed maternal battering, 19 percent who reported having witnessed maternal battering plus having

please see ***Maltreatment*** *on page 30*

Does Self-Harm Constitute Unique Personality Disorder?

Researchers propose that self-harm personality is another type of personality disorder.

BY JOAN AREHART-TREICHEL

It is not only those with borderline personalities who intentionally injure themselves without apparent suicidal intent, a new study shows. Persons who possess certain traits associated with other types of personality disorder do so as well. In fact, if these various traits are pooled, they might constitute a deliberate self-harm personality.

The study was conducted by three University of Virginia researchers—E. David Klonsky, a psychology doctoral student; Thomas Oltmanns, Ph.D., a professor of psychology and psychiatric medicine; and Eric Turkheimer, Ph.D., a professor of psychology and director of clinical training. Results of the study were published in the August *American Journal of Psychiatry*.

Klonsky and his coworkers selected as subjects for their study some 2,000 Air Force recruits. The recruits were on average 20 years of age, 62 percent were men, and nearly all were high school graduates and would eventually receive assignments as military police, mechanics, computer technicians, or other support-service personnel. The recruits also went through basic training together in "flight" groups, so that recruits in a given flight spent almost all of their time together and got to know each other quite well.

The 2,000 subjects were given the Beck Depression Inventory and the Beck Anxiety Inventory to learn whether they were depressed or anxious, and the Schedule for Nonadaptive and Adaptive Personality to learn what kinds of personality traits they possessed and whether they had ever engaged in self-harm. The subjects were also asked to use an instrument called the Peer Inventory of Personality Disorders to describe the personality traits of subjects who were in their particular flights and whom they knew well. Klonsky and his colleagues then analyzed inventory and schedule results for all of the subjects.

After that, the researchers determined the percentage of subjects who endorsed either one or both of the self-harm items in the Schedule for Nonadaptive and Adaptive Personality. The item "When I get very tense, hurting myself physically somehow calms me down" was endorsed by 2.5 percent of the men and by 2.4 percent of the women. The item "I have hurt myself on purpose several times" was endorsed by 2.5 percent of the men and by 1.7 percent of the women. Some 4 percent of all subjects endorsed at least one of these items; less than 1 percent endorsed both.

Next, to get a better idea of why people engage in deliberate self-harm, the investigators compared schedule and inventory results from subjects who reported that they had engaged in deliberate self-harm with the schedule and inventory results from those who had not.

Both depression and anxiety scores were found to be significantly higher in self-harmers than in those who didn't harm themselves. But the link between depression and self-harm was considerably smaller when the effects of anxiety were taken into consideration. Thus, self-harmers appeared to be more anxious than depressed.

Subjects with a history of deliberate self-harm were also found to report substantially more personality pathology than those without such a history, and this pathology consisted of certain features present in various *DSM-IV* personality disorders.

Further, self-harmers were discovered to be perceived by their peers as exhibiting features that are typical not just of borderline personality, but also of schizotypal, dependent, and avoidant personalities. The features were feeling empty inside, acting strangely in response to stress, showing emotional responses that are strange or out of sync, not trusting other people, being afraid of being left alone to care for oneself, and worrying that other people will reject him or her.

"Our results support the *DSM-IV* classification of deliberate self-harm as a symptom of borderline personality disorder," Klonsky and his coworkers wrote in their study report, "but also indicate that self-harm may be present in individuals with other personality disorders." In fact, if the features that describe self-harmers are pooled, they might constitute a self-harm personality, the investigators believe.

Still to be answered, of course, is why even someone with a self-harm personality chooses to engage in self-harm. Klonsky has now launched another study to answer that question, he told *Psychiatric News*. So far, he said, he has interviewed 24 subjects to find out why they engage in self-harm, and preliminary results suggest that the reason is to release emotional pressure that builds up in them. Specifically, the most common emotions endorsed as being present right before a self-harm act are "anxious," "frustrated," and "hurt emotionally," whereas the most common emotions endorsed as being presently immediately after a self-harm act are "relaxed," "calm," and "relieved."

The investigation conducted by Klonsky, Oltmanns, and Turkheimer was funded by the National Institute of Mental Health.

The study, "Deliberate Self-Harm in a Nonclinical Population: Prevalence and Psychological Correlates," is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/160/8/1501?>. ■

Resignation

Association News

Oparaguo Udebiuwa, M.D., of Davidsonville, Md., resigned from the American Psychiatric Association and from the Washington Psychiatric Society during the course of an ethics investigation. APA's "Procedures for Handing Complaints of Unethical Conduct" requires that resignations that occur during the course of an ethics investigation be reported in *Psychiatric News*. ■

PSYCHIATRIC PRACTICE & MANAGED CARE
APA OFFICE OF HEALTHCARE SYSTEMS AND FINANCING

What's Going On In Managed Care?

"We know managed care is changing," said Lawrence B. Lurie, M.D., chair of the Committee on Managed Care, "but we don't know how much." The committee suspects that the changes in managed care practices may be regional, and so it has embarked on a project to contact the district branches (DBs), state associations (SAs), and APA members to find out what is going on.

Each DB/SA president has now received a letter from Lurie asking for information on local managed care trends. "We are eager to increase collaboration between the committee and the DBs/SAs so that we can enhance our representation of the membership," Lurie emphasized.

As a point of departure, the committee asked each DB/SA the following questions.

v your area?

- Are reimbursement rates going up? Going down? Staying the same? Are claims being paid on time?
- Are there changes in preauthorization requirements, especially for CPT codes 90801, 90862, 90805, and 90807? Is there any indication that managed behavioral health care organizations (MBHOs) would be open to psychiatrists using medical E&M codes to differentiate their work from that of mental health professionals?
- What, if any, impact have the parity laws had?
- Are pharmacy benefit managers (PBMs) increasing the amount of time psychiatrists spend on prescribing? Altering their choices about first-line treatment? Creating other problems?
- Are your members taking new patients covered by managed care plans? (APA's Practice Research Network found that only 54 percent of APA members are taking new patients covered by managed care. Does this figure have a regional component?)
- Are your members spending more time on administrative duties connected with managed care? Less time? The same? Are there differences in business practices of the managed care organizations (MCOs) that make some companies more attractive to work with than others?
- Are there differences in quality among MCOs? Between local and national/regional MCOs? Between carved-out and noncarved-out systems?
- Are different employers providing widely different coverage in your areas? If so, which employers are providing high-quality mental health coverage? Which MCOs or MBHOs manage those contracts?

Based on this input, the committee, the Council on Healthcare Systems and Financing, and the APA Office of Healthcare Systems and Financing (OHSF) will work together on an agenda for 2004.

"Our office is in regular contact with many of the managed care companies to resolve individual member issues," Irvin L. (Sam) Muszynski, J.D., director of OHSF, said, "but with this outreach, we hope to broaden the scope of our conversations with these companies. We look forward to hearing from the membership."

APA members may contact the Committee on Managed Care directly via the managed care caucus's list serve at managed carecaucus@mail.psych.org or the Managed Care Help Line at (800) 343-4671. ■

Psychiatric Practice & Managed Care *(PP&MC)* and *Psychiatric News* will continue updating APA members on practice management issues via the pages of *Psychiatric News*. This abbreviated version of *PP&MC* will be printed bimonthly in *Psychiatric News* and will coincide with the posting of each new issue of *PP&MC* on APA's Web site. To access the newsletter, go to <www.psych.org>, click on "Members Corner," and scroll down to "Newsletters."

Practice Issues Dominate Managed Care Help Line

Of the 319 calls to APA's Managed Care Help Line during the second quarter of 2003, only 72 (23 percent) were complaints about managed care. "We're finding that members call more often now about a wide range of practice issues, such as coding, Medicare, and which software to buy, than they did several years ago," said Karen Sanders, Help Line manager.

The complaints about managed care usually focused on unpaid claims, denials, and audits, and most of the callers about Magellan were seeking information about the company's bankruptcy. According to Sanders, the complaints about Magellan, United Behavioral Health, and ValueOptions were resolved fairly easily. ■

Help Line Complaints on MCOs, Insurers
Second Quarter, 2003

Insurer Issues	2nd Qtr	1st Qtr	2003 Total	Unresolved
Magellan	15	18	33	0
UBH	2	4	6	0
Cigna	2	5	7	8
Various Blue Crosses Nationwide	8	8	16	2
Oxford	3	3	6	4
MHN	0	2	2	0
Aetna	1	1	2	0
APS	0	2	2	3
Secure Care	2	0	2	0
Tricare	2	0	2	0
Various State Medicaid Plans	11	2	13	0
ValueOptions	5	1	6	0
VA	0	1	1	0
Miscellaneous*	21	46	67	2
Total	**72**	**93**	**165**	**19**

***Miscellaneous:** companies with few complaints or not big enough to have a separate category of tracking*

"Opting Out" Of Medicare

APA members continue to call about "opting out" of Medicare, according to Ellen Jaffe, Medicare specialist in the Office of Healthcare Systems and Financing. Although the Office of Healthcare Systems and Financing can provide psychiatrists with that information, APA members should know that information about opting out of Medicare, along with a contract and affidavit necessary for completing the task, can be found on APA's Web site at <www.psych.org/members/practpsych/optingoutofmedicare112701.cfm>.

Opt-Out Details

Physicians who opt out of Medicare —meaning Medicare cannot be billed for any services they provide for a two-year opt-out period—can see Medicare patients under private contracts. These contracts allow physicians to establish their own fees; they are not limited by the Medicare fee schedule.

A physician who opts out of Medicare may not see any Medicare patients for two years. Medicare patients can, however, choose to see some physicians under Medicare and others under private contracts.

Physicians must send an opt-out affidavit to their local Medicare carrier before entering into private contracts with patients. Nonparticipating providers can opt out at any time, while participating providers must send the affidavit to the carrier 30 days before the beginning of the following quarter when their opt-out period will begin (the quarters begin on 1/1, 4/1, 7/1, and 10/1).

The private contract must say that the patient agrees in writing that he or she will not submit any claims to Medicare and will not ask the physician to submit any claims. The patient also acknowledges that Medigap plans (and possibly other supplemental plans) will not make payments for services rendered by the contracting physician, agrees to be fully responsible for payment to the contracting physician for services rendered, and acknowledges that Medicare's fee schedule amounts and charge limits do not apply to the contracting physician. The private contract available on the APA Web site fulfills all the requirements.

APA members may call Ellen Jaffe, Medicare specialist, at (703) 907-8591 or e-mail her at <HSF@psych.org>. ■

Coding Physical Exams

Q. As a cost-cutting measure, my hospital is requiring attending psychiatrists to perform the required physical on every patient who is admitted to the psychiatric unit. I feel this is out of my scope of practice and my experience. So far, I have managed to see only patients whose insurance will cover the physical separately by an internist or someone else. How should this be coded?

A. As medical doctors, psychiatrists have been trained to do physicals. In some facilities the psychiatrist does both the initial evaluation and the physical; in others, the psychiatrist does just the initial psychiatric evaluation and someone else (for example, an internist) does the physical. Either practice is acceptable.

If the psychiatrist does the initial evaluation and physical, he or she can use 90801 or one of the 99XXX codes under "Initial Hospital Care" (for example, 99221, 99222, or 99223). If the psychiatrist does the initial evaluation and someone else does the physical, the psychiatrist can use the 90801 code, and the person doing the physical can use one of the 99211-99223 codes.

E-mail your CPT coding questions to HSF@psych.org, attention Becky Yowell, assistant director of the Office of Healthcare Systems and Financing. ■

CPT Coding and Documentation Answers Available At Boston Institute

Chester W. Schmidt Jr., M.D., chair of APA's Committee on RBRVS, Codes, and Reimbursements, will present a half-day course on CPT coding and documentation on October 30 at APA's Institute on Psychiatric Services in Boston. Schmidt will explain the CPT codes used by mental health clinicians, discuss problems associated with payer-imposed barriers to payment, and review documentation procedures. Register online through APA's Web site at <www.psych.org> or call (703) 907-7810. ■

APA's Ethics Procedures Changing

BY WADE MYERS, M.D.

There have been substantial changes to APA's Procedures for Handling Complaints of Unethical Conduct that have been brewing for the past couple of years and are now official APA policy following approval by the APA Board of Trustees in November 2002. These changes are (1) the addition of an "Educational Option" to the traditional enforcement model, (2) the transfer of ethics appeals to the APA Ethics Committee, and (3) the imposition of a statute of limitations for ethics complaints.

This column will provide a brief overview of these changes, why they occurred, and how they will impact the ethics-enforcement process. Of note, these changes were presented at two well-attended back-to-back ethics workshops at APA's 2003 annual meeting in San Francisco. The workshop presentations were followed by vigorous, insightful discussions.

As members and staff of APA and district branch ethics committees well know, discussions of ethical issues tend to be lively and passionate, taking on a life of their own. Strong convictions about ethics are the rule rather than the exception among APA psychiatrists, a vibrant sign of our organization's health that its members hold in such high regard the ethical practice of psychiatry.

Dr. Myers is vice chair of APA's Ethics Committee.

- **Educational Option**

This change will have the greatest impact on the APA ethics process by making available a second pathway, the Educational Option, to complement the traditional Enforcement Option pathway. This innovation answered concerns that APA ethics enforcement was too adversarial and lacked sufficient emphasis on education. Historically, APA's principal mission in the area of ethics, as with many medical organizations, has been one of education.

In determining which approach to use, district branches will take into consideration such factors as the nature and seriousness of the alleged misconduct and prior findings or allegations of unethical conduct. The goal of the Educational Option is to allow district branches to resolve complaints in an educational rather than enforcement atmosphere.

A major benefit to the members to whom the Educational Option applies is that they avoid the potential stigmatization following a formal finding of an ethical violation. The district branch shall "make no determination as to whether the respondent has violated the Principles"—provided the respondent cooperates with the plan.

The Education Option is designed for less-serious allegations of unethical behavior that necessitate action on a district branch's part, yet don't convincingly rise to a level of infraction—if proved true—that calls for a sanction. The use of the phrase "less serious" is not meant to imply that ethical violations at the lower end of the culpability spectrum are not serious. An analogy in our justice system is a legal charge that is not prosecuted, provided the defendant satisfactorily participates in a program of remediation (for example, driver education class, anger-management training). Previously, district branch ethics committees were faced with the minimal sanction of a reprimand for those members who might otherwise now fall into the Educational Option category, a conundrum for district branches when the violation called for some degree of intervention, yet a formal reprimand seemed too heavy-handed.

District branches have considerable latitude in devising an educational plan, allowing room for individualized, creative plans. Interventions might include meeting with the member with or without the complainant, or, after completion of procedures used by the district branch, requiring participation in a CME course and assigning readings or a consultative/supervisory experience.

The choice of whether to accept a district branch's offer of the Educational Option pathway rests with the accused member. He or she may choose not to accept this option and, instead, to have the complaint investigated and resolved pursuant to the traditional Enforcement Option procedures. However, if the Educational Option is chosen and at any time the district branch decides that the respondent has not cooperated with its consideration of the complaint, including participating in a manner appropriate to an educational experience and complying with any educational steps required by the district branch, it may inform the respondent that the case will be returned to the Ethics Committee for processing pursuant to the Enforcement Option or that the respondent's name will be forwarded to the APA Board of Trustees with a recommendation that the member be dropped from APA.

Readers are invited to submit opinion pieces on issues facing psychiatry for possible publication in this column. They may be on an original topic or in response to previous "Viewpoints" articles. Those interested should contact Ken Hausman at *Psychiatric News* at (703) 907–7861; e-mail: KHausman@psych.org.

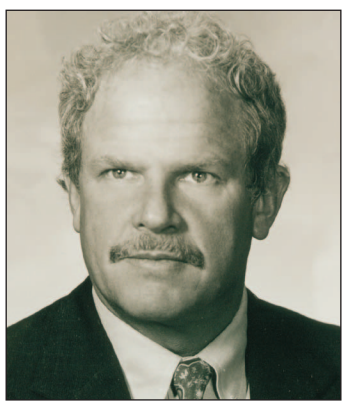
- **Transfer of Ethics Appeals to the APA Ethics Committee**

As of January 1, the APA Ethics Committee, rather than the Ethics Appeals Board, is the next level to which a case advances when the involved member requests an appeal. A panel of three APA Ethics Committee members who have not been involved in any review of the case beforehand will consider the appeals. This modification was brought about by the rationale that the Ethics Appeals Board was unnecessarily cumbersome and expensive for the organization given fiscal restraints, and this new process would not jeopardize a member's right to an appeal heard by a neutral, fitting body. This new appeals process will allow cases to be decided solely on the basis of the district branch's documentary record and written appeal statements filed by the respondent. No longer will respondents be able to appear in person before the Appeals Board. Members appealing decisions regarding complaints received by the district branch prior to January 1, 2003 will still be entitled to have their appeals heard by the Ethics Appeals Board. However, if such a case has been reviewed by only half of the APA Ethics Committee, leaving the other half free to hear the appeal, and the member agrees to have his appeal heard by

please see ***Viewpoints*** *on page 32*

Formularies Nothing But Trouble

BY WILLIAM M. GLAZER, M.D.



The Viewpoints column by Dr. James Sabin in the April 4 issue argued for the virtues of restrictive psychiatric formularies. The column is timely, given the chaotic events that have been occurring in various states around attempts to restrict access to psychiatric medications.

Dr. Sabin's viewpoint is in opposition to that of APA as well as a collaborative effort by APA, the National Alliance for the Mentally Ill (NAMI), and the National Mental Health Association (NMHA) whose purpose is to advocate for open access to psychiatric medications.

While Dr. Sabin's opinion may be commonly shared among administrators, payers, and some clinicians struggling with draconian budget deficits, it is not consistent with that of the average mental health "advocate."

Let's look at whether the evidence supports the rationing of psychiatric medications, particularly the antidepressants and antipsychotics. These are the classes of psychiatric medications that have received the most attention from payers.

Dr. Glazer is an associate clinical professor of psychiatry at Massachusetts General Hospital and Harvard Medical School and is president of Glazer Medical Solutions.

While there are individual comparative studies that might support the argument that some agents within these two classes are interchangeable, there are no definitive studies that lend clear scientific support to this notion. You can check my Web site at <www.medaccessonline.com> for extensive background information on the new-generation antipsychotics.

I have been an early bearer of the notion that when treatments are equally effective, go with the less-expensive option. However, when it comes to antidepressants and antipsychotics, this is not the case. We can certainly debate the question, but no expert can say with certainty that the antipsychotics or antidepressants are "equally" substitutable within their respective classes.

In addition to the absence of definitive comparative data, there are other sources of evidence that should caution those who want to restrict psychiatric formularies. A 1994 study by Soumerai, et al., demonstrated to New Hampshire Medicaid payers that restrictions placed on use of conventional antipsychotics may have reduced the amount of spending on these medications, but led to a 17-fold increase in consequent costs of clinical services.

More recent studies of the general impact of formulary restrictions consistently demonstrate resulting inefficiencies. Studies such as these led the NMHA to publish Penny Wise and Pound Foolish (<www.nmha.org/state/pennywise.pdf>) and NAMI to disseminate the findings from its NAMI Policy Research Institute's Access to Medication task force (<www.nami.org/update/000709.html>).

Putting the controlled studies to the side, any experienced clinician, family member, or patient/consumer knows that the chemical structures of these agents vary tremendously, and with that, we see individuality of response—from both efficacy and safety perspectives.

I fear that the basis to argue for formulary restrictions derives more from concerns about drug acquisition costs than from any rational, clinically scientific concern. I am afraid that politics is speaking louder than science.

If we do choose to ration medications, what then are the "best practices"?

There are many strategies—even "realistic" strategies—that can assure cost-effectiveness in the treatment plan. First, the biggest gap to success in this area is the absence of integrated information systems to connect formulary design with clinical outcomes. Rarely is any system of care able (or willing) to measure the impact of formulary decisions on long-term (greater than six months) consequences.

Second, drug utilization review (DUR) should become a leading mechanism to deter "careless" or "unnecessary" prescribing. Regulatory agencies have gotten us to "go through the motions" of DURs, but it is time that we start taking the process seriously.

Third, prescriber education separate from, but also coordinated with, solid pharmaceutical company support offers valid methods to promote efficiency. Incidentally, the Food and Drug Administration ought to follow colleagues in other countries who require pharmacoeconomic data for approval of new medications.

Finally, we are learning that there are legitimate ways to leave the decision making to the prescriber while aligning his/her financial incentives toward efficiency; that is, when our prescribing behavior is connected to our service rating.

If we are going to restrict treatment options, let's be sure that the policy follows the science and that a publicly transparent decision-making process is employed. Let's be sure that we measure the impact of whatever we do on the lives of our patients and their families and hold ourselves accountable to them.

If you don't believe me, APA, NAMI, or NMHA, read the recent subcommittee report on evidence-based practices on mental health policy and psychotropic drugs in the report of the President's New Freedom Commission on Mental Health posted at <www.mentalhealthcommission.gov>. ■

Risk Info, PDAs, and Certificates

Q. I recently joined the Psychiatrists' Program, the APA-endorsed Professional Liability Insurance Program, and received my first issue of the risk-management newsletter *Rx for Risk*. I found it quite useful and was wondering if an archive of past articles is available?

A. An online archive of more than 100 psychiatric risk-management articles from *Rx for Risk* is now available to participants on The Program's Web site at <www.psychprogram.com> by logging in to "For Participants Only" to access the new Online Risk Management Library. Finding practical risk management information relevant to your psychiatric practice has never been easier with the addition of a search function and drop-down menus. Articles are also categorized by topic, including forensic issues, records, documentation, confidentiality, and more.

A selection of complimentary risk management articles is also available for nonparticipants in the risk-management section of the Program's Web site.

Q. My personal digital assistant (PDA) came with free medication information software. I can access a humongous amount of medication information. The program also comes with an alert function that will notify me if I prescribe medications that the patient is allergic to or multiple medications that might interact adversely with one another. Since I treat patients with comorbid, complex somatic illnesses, I'm always worried that medications I prescribe will adversely react with a medication prescribed by the somatic physician. Does using such a product reduce my risk of professional malpractice liability?

A. Using readily available computer software, psychiatrists can access a vast amount of medication information. Computer programs designed to catch potentially adverse medication interactions offer the promise of safer prescribing and do have the potential to reduce malpractice liability risk.

Regardless of this technological revolution, however, the standard of care remains the same. The psychiatrist bears the ultimate responsibility for prescribing appropriately and could be held liable for unreasonable reliance on misinformation or the misuse of accurate information.

The psychiatrist should be comfortable that the information retrieved by computer programs is accurate, complete, and up to date. Due to potential programming errors, the psychiatrist should verify patient medication allergies through medical-record documentation and with the patient rather than relying solely on the computer program's alert function. For patients in treatment with multiple providers for comorbid illnesses, the risk of adverse medication interaction is, of course, greatly increased. Medication-interaction programs offer a great safety net and can thereby improve patient care. The computer program cannot, however, alert the psychiatrist to a potential interaction if the psychiatrist is unaware of a medication prescribed or dosage altered by another provider.

For this reason, communication among treatment providers is the primary risk-management approach to preventing adverse medication interactions. All treatment providers should obtain patient consent and communicate with each other. The psychiatrist can then discuss with the physician(s) treating the somatic conditions the patient's medications and potential interactions, overall treatment plan, and clinically significant events.

Medication information programs offer a safety net that can lead to safer prescribing and treatment. If you are so inclined, use them. The technology, however, is only one aspect of safe prescribing. The treating psychiatrist's expertise and professional judgment are what ultimately count.

Q. I am a Program participant and need to obtain a certificate of insurance. What is the quickest and easiest way to request a certificate?

A. To facilitate requests such as for a certificate of insurance, we recently established a new 24-hour Program Customer Care Line at (800) 245-3333, ext. 332. Just follow the automated instructions and a certificate will be sent within two business days after the request is received. Participants can also call this toll-free line to follow up on recent payments or check on renewal policy status. You can also e-mail your requests or questions at TheProgram@prms.com.

This column is provided by PRMS, manager of the Psychiatrists' Program, for the benefit of members. More information is available by visiting the Program's Web site at <www.psychprogram.com>; calling (800) 245-3333, ext. 389; or sending an e-mail to TheProgram@prms.com. ■

Errata

• In the September 19 issue, the toll-free telephone number cited for APA's Advocacy Action Center was incorrect. The correct number is (888) 35-PSYCH. We regret the error. The Advocacy Action Center is a free service of APA's Division of Government Relations, and its purpose is to keep APA members informed of all federal legislative and regulatory developments and make it easy for them to become grass-roots activists on behalf of their patients and the profession of psychiatry. Here members will find "Action Alerts" on current issues needing member advocacy, information on important bills and regulations, and links to contact members of Congress at the click of a mouse. More information is available by calling (888) 35-PSYCH or visiting the Web site <http://capwiz.com/psych/home/>.

• The History Notes column in the August 1 issue contained two errors. The name of E.W. Lazell was misspelled, and Samuel R. Slavson was not a psychiatrist, as indicated; he was a lay analyst. ■

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C-L Psychiatry's Impact Overlooked

BY DAVID STRAKER, D.O.

The education of medical students and young physicians has evolved over the past several years with the advent of evidence-based medicine and a greater focus on clinical skills.

At the same time the field of consultation-liaison (C-L) psychiatry has grown significantly, with an increase in the number of programs and fellowships offered across the country, a greater number of training hours in C-L required for psychiatry residents, and recent approval of subspecialty status. In addition, at many medical centers C-L psychiatry is becoming a part of both medical student education and internal medicine residencies.

More and more programs like the one at which I am chief resident (Long Island Jewish Medical Center) are giving C-L lectures, courses, and even rotations to their medicine residents. Young internists are learning skills such as how to talk to a patient about proxy issues and about breaking bad news, death and dying, and coping with cancer. Medical students are also learning about these topics, and some are spending entire clerkships in C-L psychiatry.

As a third year medical student, I was fortunate to have had a C-L psychiatry clerkship. It helped me significantly in all of my third-year clerkships, as well as in attracting me to the field of psychiatry. Unfortunately, more than half of my colleagues never got a taste of C-L psychiatry. They did traditional inpatient psychiatry clerkships and later went into their medical residency programs having learned little about the field except for such disorders as schizophrenia, bipolar disorder, and major depression. In medical schools, few classes focus on ethics and the doctor-patient relationship. No wonder so few young docs feel comfortable breaking bad news to patients and their families.

I remember being a medical student on my internal medicine rotation and being told to break the bad news to a previously healthy patient that he had brain cancer. Both the attending and medicine chief resident "passed the buck" to me. Fortunately, I had had my C-L psychiatry rotation and felt confident despite being "the third-year medical student wearing the short white coat." Yet students and interns are often thrown into these situations by their superiors and are left feeling uncomfortable and unsure of how to handle them.

So what can we do about this? First, we can train more students and young physicians earlier on. Many programs, as I have mentioned, are educating their medicine residents in the above skills, and more medical schools are having their students do C-L clerkships during their third year. A great start, but the problem remains that the majority of medical centers and medical schools do not expose their students or residents to this area of psychiatry. Had I not done a C-L psychiatry clerkship, I probably would have not entered the field of psychiatry and would have gone into pediatrics.

Another problem resides in the fact that most of these "programs" that teach clinical skills focus on medicine residents and fail to educate those in surgery, obstetrics/gynecology, and other specialties.

The primary question I pose is whether a C-L psychiatry rotation should be mandatory for graduation from medical school. As students we have many requirements including 12 weeks of surgery, a number of clerkships in primary care medicine, and many electives, but no C-L psychiatry clerkship. Could we add in a four- to six-week rotation in this field of psychiatry? I believe that future doctors would then become more "empathic, caring docs."

As chief resident in psychiatry, I still hear students asking to spend time on a C-L psychiatry clerkship. Unfortunately, only a few will get that chance.

One of the three medical schools that send students to our institution has none of their students rotate on the C-L service, while the other two have half of their students on the service. Thus, even at an institution that trains one of the largest numbers of medical students in psychiatry in the country and has one of the largest C-L psychiatry fellowships, only a third of students are exposed to C-L psychiatry. This is quite unfortunate—unfortunate for psychiatry in that it will lose potential residency candidates and unfortunate for medicine in that it will have fewer doctors who have the tools to become "complete" physicians.

There is a lot we can do, and I am hopeful that the next generation of physicians will feel more comfortable and confident talking about difficult issues with their patients. In my limited role as teacher and mentor to interns and medical students, I hope to have an impact in helping them reach that goal. ■

Dr. Straker is PGY-4 chief resident at Zucker Hillside Hospital of Long Island Jewish Medical Center in Glen Oaks, N.Y.

Psychiatric Slavery?

In her column in the July 18 issue titled "The 'Suicide-Prevention Contract': A Dangerous Myth," APA President Marcia Goin, M.D., asserted: "We can make contracts with builders, insurers, and car dealers, but not with patients." Mental patients are not legally incompetent. Builders, insurers, and car dealers make contracts with mental patients. Why can't psychiatrists make contracts with them?

Dr. Goin makes her sweeping statement in the context of rejecting the so-called no-suicide contract, but her statement places no limits on the no-contract principle with mental patients. On the contrary, she tacitly underscores that coercive paternalism is the bedrock principle of psychiatry: "When entrepreneurs break a contract, the rupture stirs a multitude of negative feelings, and legal action may follow. But a broken 'no-suicide' contract stirs tragic feelings for all involved. No amount of legal action can restore the patient's life."

I wish to offer three brief observations:

- Dr. Goin is a psychoanalyst, a member of the American Psychoanalytic Association. If the relationship between analyst and patient is not a contract, what is it? Do psychoanalytic patients fall outside Goin's category of "our patients"?
- Suicide is not illegal. Americans have a right to kill themselves. Psychiatrists deny the basic right of self-ownership to patients, but not to themselves. The patient who commits suicide does not "lose" his life. He takes it (into his own hands). Hence, there is nothing to "restore."
- Dr. Goin noted that the damage caused by broken contracts is remedied by legal action, but she fails to mention that the principle applies to the suicide-prevention "contract" as well. When mental patients commit suicide, survivors hold the psychiatrists responsible for defaulting on their contracts to protect patients from themselves.

Without Consent or Contract is the title of historian Robert William Fogel's important book on slavery. Those words summarize the essence of the immorality of the institutions of chattel slavery and psychiatric slavery. The concepts of consent and contract imply relations between persons who recognize one another's personhood. That recognition was incompatible with slavery and is, according to the president of APA, incompatible with psychiatry.

THOMAS SZASZ, M.D.
Manlius, N.Y.

Dr. Goin responds:

I thank Dr. Szasz for taking the time to communicate his thoughts on my recent column. A collaborative working relationship between patient and physician is important in all fields of medicine. This is particularly true in psychiatry, where so much is dependent upon patients' ability and emotional freedom to talk about how they feel, their desires, and their impulses. Suicidal ideation is a case in point. Collaboration, not slavery, is the answer.

Psychodrama Lives

In the May 16 *Psychiatric News*, there is a "History Notes" article about my late husband, J.L. Moreno, M.D. While I appreciate Dr. Lucy Ozarin's interest in his life, her statement that psychodrama as a therapeutic technique appears to have receded is incorrect.

Far from receding in the United States, the study, practice, and growth of psychodrama are very much alive and flourishing in the 21st century. The United States has a Board of Examiners in Psychodrama, which certifies practitioners on three levels. Most of these practitioners are nonpsychiatrists, but many work under psychiatrists. Next month I will travel to the University of San Jose in California to dedicate the Moreno Institute West within its School of Education.

In therapeutic circles, some practitioners and trainers have enthusiastically integrated the psychoanalytical perspective with psychodrama, while other clinicians use aspects of psychodrama without designating them as such. Further, there are many who may be unaware that much of their work derives from Moreno's work in psychodrama. Frequently other terms have been substituted, such as role play, action methods, experiential therapy, interactive methods, expressive therapy, enactment, and simulation. The sociologists would describe this phenomenon as "Moreno having been absorbed by the culture."

There are psychodrama training and treatment centers, as well as individual practitioners, around the globe. Moreno organized the International Association of Group Psychotherapy in 1951; it has several subsections of which psychodrama is one. Many of its members are psychiatrists.

Training centers can be found in practically every European country. Psychiatrists who identify themselves as psychodrama specialists are especially numerous in the Latin American countries. Brazil alone has 6,000 persons in the Federation of Psychodrama Specialists.

Moreover, Moreno is regarded abroad as a philosopher and an outstanding pedagogue. In Germany, for example, there are two Moreno Institutes and five other psychodrama training centers. The largest number of practitioners are psychiatrists, followed by psychologists and social workers. In addition, several journals in Germany are dedicated to psychodrama and its ever-growing literature. Also, there are two schools in Germany named Jakob Moreno Schule. One school applies his methods to help children with learning difficulties; the other is for post-psychiatric and post-psychologically treated young people. It is mainly staffed by persons trained in one of the psychodrama centers in Germany.

Regrettably, psychiatrists in this country do not take seriously a method—it is not a technique—that is yielding remarkable results. It is their loss.

ZERKA T. MORENO
Charlottesville, Va.

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.

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health care economics

Strategies

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that would not translate into a scalable model for Medicare to implement nationally," she said. "What they are doing is testing types of interventions, not a program structure that could be readily scaled up."

While the opportunities for cost savings and improvement in health outcomes is great, the challenges of introducing DM on wide scale in the Medicare program are significant.

"One major challenge is that the CMS needs to develop the infrastructure to support the real-time use of patient claims data," Foote said. "In addition, there need to be a lot of policy decisions about where [CMS officials] think they are most likely to have a positive impact. And CMS will have to work very closely with whatever contractors it engages to ensure that DM is executed in a way that is supported by beneficiaries and physicians."

The patient population in Medicare is likely to present challenges not found in the private sector. "There are 35 million people in the fee-for-service Medicare plan, and the range of problems is very broad," Foote said. "They will have a lot of problems related to language, education, multiple chronic conditions, and cognitive difficulties."

Foote also said that mental illness is a critical component in the cost of caring for the Medicare population. Among beneficiaries under age 65, mental illness accounts for 13 percent of their total health care costs. And that segment of the Medicare population is expanding—between 1995 and 1999, enrollment of nonelderly people in Medicare went up by more than 800,000, or more than 18 percent, Foote said.

There is some precedent for offering DM for mental illness in the public sector. Sandeep Wadhwa, M.D., is a geriatrician and vice president for sales and marketing for the McKesson Corporation, a Broomfield, Colo., company specializing in disease management. McKesson has been offering a version of DM for Medicaid patients with depression in Washington, Florida, Mississippi, and Colorado. Though he would not reveal financial data about the company's performance, he said the programs have been successful in saving state Medicaid dollars.

"These programs are budget neutral for the state," he told *Psychiatric News*. "They pay us for administrative services, and we guarantee a savings offset in the form of claims reductions."

Wadhwa said that the program offers depression screening to Medicaid patients and, on the basis of results, coordinates care with whatever mental health network is in place, or works with the primary care physician to find a "medical home" for the beneficiary.

"A lot of time we are coordinating with the mental health carveout and plugging people into a system they haven't touched before," he said. "We think there is a real dimension of social isolation we are addressing through our outreach mechanism, by plugging people back into a support network."

Foote's article is posted online at <www.healthaffairs.org/WebExclusives/Foote_Web_Excl_073003.htm>. ■

Parity

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Administration that reviews the first three years of the state's parity mandate. There, too, warnings of skyrocketing costs and a rush of employers to self-insure to avoid the mandate turned out to be groundless.

The report studied the experience of the two insurers—Blue Cross/Blue Shield of Vermont (BCBSVT) and Kaiser/Community Health Plan—that covered 80 percent of Vermont's privately insured population when the parity law took effect on January 1, 1998.

Following parity, BCBSVT saw the cost of providing mental health and substance abuse treatment increase from 2.3 percent of spending for all services to 2.47 percent, an increase of about 4 percent. Monthly costs per beneficiary increased by 19 cents.

At Kaiser, the smaller of the two insurance plans, spending on mental health and substance abuse services decreased by an impressive 9 percent after the parity mandate's implementation. The bad news for parity advocates in that statistic, however, is that "decreases in utilization of [substance abuse] treatment services" accounted for almost all of this spending reduction, the report pointed out.

In terms of access to care, parity significantly improved the likelihood of insured individuals obtaining mental health treatment, with increases ranging from 18 percent to 24 percent, the report noted. There was also an increase in the number of outpatient visits per use.

Again, however, the sword turns out to be two-edged. "For BCBSVT members who received the [mental health/substance abuse] benefits through the carveout, the use of managed care arrangements offset the effect of parity. For these members, the odds of obtaining treatment and the average number of outpatient visits per user declined," the report stated. BCBSVT had turned to a mental health carveout to manage its beneficiaries' use of mental health and substance abuse services. (Kaiser kept its previous managed-care plan in place when it added benefits to comply with the parity law.)

At Kaiser, access to inpatient or partial treatment saw a substantial drop. "There was a 32 percent lower likelihood of obtaining inpatient or partial MH treatment following parity," the report stated, "as Kaiser attempted to target inpatient care more efficiently, increasing the use of stepdown or diversion programs as an alternative to hospitalization." Use of outpatient services, however, increased under parity.

Substance abuse treatment was more difficult to access in both health plans after parity—51 percent lower in Kaiser and 34 percent lower in BCBSVT.

The Vermont report stated that "managed care. . .was an important factor in controlling costs following implementation of parity. . . . Increased use of managed care helped make parity affordable, but may have reduced access and utilization for some services and beneficiaries."

As for the warnings that employers would stop insuring workers at all as a way to avoid the parity mandate, only 0.3 percent of employers dropped coverage in reaction to the parity law, and "there was no evidence that a significant number of employers chose to self-insure to avoid the parity mandate," the report noted. Only 3 percent of employers turned to self-insurance for this reason.

"Both the South Carolina and Vermont experiences show that the cost of parity is easily achievable without breaking the bank. The data are in keeping with three reports to the Senate Appropriations Committee since 1997" showing that parity will involve only minimal cost increases, emphasized Darrel Regier, M.D., director of APA's Division of Research and the American Psychiatric Institute for Research and Education, in an interview with *Psychiatric News*. It is troubling, he added, that "the level of care management in administering this benefit may be reducing access unnecessarily. We have to keep monitoring both quality of and access to care under parity laws, particularly for people with less-severe illnesses." ■

from the president

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trials comparing the efficacy of different psychopharmacologic approaches to symptom spectra commonly suffered by these patients are noted. The evidence also includes four published randomized, controlled studies of psychotherapy. These were all long term, and one paper had an 18-month follow-up with impressive positive data.

Explicating Evidence-Based Medicine

To quote Sackett again, "It [evidence-based medicine] is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients." An example in the guideline of this principle is the recommendations regarding the use of MAO inhibitors. Although the efficacy of MAO inhibitors is equal to that of SSRIs for reducing affective dysregulation in patients with BPD, they are not a first-line choice in the treatment algorithm. In the context of informed consent for the use of MAO inhibitors, safety considerations are heightened for patients who are impulsive and suicidally vulnerable. The potentiation of sympathomimetic drugs or related compounds by MAO inhibitors may produce hypertensive crises. High concentrations of tyramine or dopamine in aged cheese, beer, wine, liver, dry sausage, fava beans, and excessive intake of caffeine may also generate hypertensive crises. Impulsive or suicidal patients may forget or purposely ignore these dietary limitations. Treatment with an SSRI avoids this considerable risk.

Evidence-based medicine requires us to evaluate the validity and reliability of the available evidence, but not lose sight of the limitations of this evidence. Common problems are that trials are small, have a short duration, rely on surrogate outcomes, or use controls of uncertain validity. Presented with internally valid, well-conducted trials, sensitive clinicians will still face the need to determine how to apply this evidence to our individual patients.

Psychiatrists practicing evidence based-medicine will identify and apply the most efficacious interventions to maximize the quality of life for their patients. This is not a cost-saving device. Adoption of this clinical strategy may raise rather than lower the cost of patient care.

Is evidence-based treatment of patients suffering from BPD an oxymoron?

The answer is clearly "No." Unfortunately, we can't say the same for airline food or postal service. ■

clinical & research news

Kleptomania

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onset of compulsive buying for two others; and alternated over time with a mood disorder for six.

The researchers then used the Schedule for Affective Disorders and Schizophrenia-Lifetime Version Modified for the Study of Anxiety Disorders and the Minnesota Impulsive Disorder Interview to assess all of their 99 subjects for anxiety and depression, sensation seeking, and impulsivity.

The investigators then compared the results for the kleptomania subjects with those for the subjects with other kinds of psychiatric disorders and to the results for subjects with alcohol abuse or dependence.

The researchers could find no statistically significant differences between the kleptomania subjects and the other two groups as far as anxiety and depression were concerned.

However, they did find that the kleptomania subjects and the alcohol-abusing subjects had significantly higher scores on sensation seeking than did the subjects with other kinds of psychiatric disorders. And they found that the kleptomania subjects had significantly higher impulsiveness scores than the other two groups.

These findings suggest that individuals with kleptomania are not driven to engage in it because of obsessions or compulsions or because of a need to abuse substances. However, they may be propelled toward it to some degree because of anxiety and depression and because of a need for thrills, but most of all because of their impulsivity.

In fact, "because kleptomania is characterized by a low rate of comorbid substance-related disorders other than nicotine dependence and by severe psychopathology, it could be an appropriate disorder in which to study the information processes and psychobiology underlying impulsivity," Bayle and his team suggested in their study report.

The study, "Psychopathology and Comorbidity of Psychiatric Disorders in Patients With Kleptomania," is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/160/8/1509?>. ■

Maltreatment

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been physically or sexually abused, and 20 percent who reported having witnessed maternal battering plus having been physically and sexually abused had a low mental health score as an adult.

"The overwhelming majority of the [study] participants were white and had at least some college education," Edwards and her team wrote in their study report, "hence additional studies should be performed to confirm these findings with more demographically diverse groups. Even higher abuse prevalences may have been obtained had a more diverse group of respondents been included."

The study was financed by the Centers for Disease Control and Prevention, the Association of Teachers of Preventive Medicine, and the Garfield Memorial Fund.

"Relationship Between Multiple Forms of Childhood Maltreatment and Adult Mental Health in Community Respondents: Results From the Adverse Childhood Experiences Study" is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/160/8/1453?>. ■

ASTRAZENECA
AKATHISIA
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Medicare

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Fees are established according to an equation known as the Resource-Based Relative Value Scale (RBRVS). The RBRVS, developed in the 1980s by Harvard economist William Hsaio, M.D., was intended to be a data-driven method for determining the value of a physician's work involved in every type of medical encounter for which there exists a reimbursement code.

The fee is arrived at by adding the "relative value units" of a physician's work, the "practice expense" relative value unit—which is a measure of costs involved in a clinical encounter—and the malpractice relative value unit. The sum of these components is a total relative value unit (or RVU) adjusted for geographic variation. This RVU is then multiplied by a "conversion factor"—a variable determined by Congress—to arrive at a fee for each reimbursement code.

The process by which the conversion factor is developed, however, is largely secret. And built into it is a mechanism by which Congress can adjust overall spending on the Medicare program whenever the volume of physician services increases.

This mechanism allows Congress to maintain budget neutrality: If service volume goes up, part of the formula will account for it in the form of a reduction in fees.

Some physician groups say the payment rates are causing doctors to cease treating new Medicare patients. The American Academy of Family Physicians, for instance, said that a survey of its members indicated that the number of family physicians not accepting new Medicare patients increased by 28 percent following the 5.4 percent payment rate cut in 2002.

AAFP President James Martin, M.D., said the announced rate cuts for 2004 will exacerbate the problem. "The administration may not be in touch with reality," he said. "The academy's own surveys show that more than 1 in 5 of our doctors are not even taking new Medicare patients now. Lower reimbursement rates will only add to that problem. There will be an access problem." ■

MH Commission

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"She's excellent at reaching shared goals and capable of handling a huge amount of responsibility," he said.

Childs takes a broad view of who her constituencies are. "It's not only patients and their families," she said. "It's the communities in which they live, those who provide mental health services, and the legislature."

She is known for an inclusive approach toward advocacy and mental health issues.

Toby Fisher, executive director of the National Alliance for the Mentally Ill–Massachusetts, told *Psychiatric News*, "Beth was our first and only choice for the position. She spoke at our rallies, took time from her work to advocate for patients and their families, and at every turn talked about the needs of people with chronic mental illness."

In a letter of support, Fisher wrote, "We cannot say enough about the expertise and help she has given NAMI. . . .Her stature within the mental health community has grown even more over the past several years."

Childs takes a similarly broad view about the role of psychiatrists in advocacy. "Multiple disciplines are involved in the delivery of care in the mental health system," she said. "We should see ourselves as part of a big picture."

She has considerable experience in both the public and private sectors and in various aspects of psychiatry and administration.

Childs completed her residency in psychiatry at the Massachusetts Mental Health Center, where she was chief resident in adult psychiatry, and completed training in child psychiatry at that center and the Gaebler Children's Center.

She has held academic appointments at the Massachusetts Institute of Technology, Harvard University, and the University of Cincinnati.

What about those areas of disagreement, such as mandatory treatment, that divide mental health advocates?

"It's important to listen and to explain," she said. "I'll be meeting with groups of all kinds in my new position."

Childs said she was impressed by the "desire to do things well" of the state employees. "Their commitment is quite something," she said.

Speaking for herself, Childs said, "I thought it would be the kind of job in which gratification is delayed, but I was pleasantly surprised. It's such an immediate reward to be in a position in which I can help look out for people's best interests and make decisions that help them." ■

viewpoints

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an Ethics Committee panel, rather than the Appeals Board, the appeal will be heard by the committee. Once these appeals are exhausted, the board will be dismantled.

- **Statute of Limitations**

The third change to the ethics process is the imposition of a 10-year statute of limitations. For patients who were minors at the time of the alleged infraction, the 10-year limitation period will begin once the patient reaches the age of majority, age 18 in most states. This change was enacted for two main reasons: evidence and witnesses tend to be less available and reliable over time, and district branches don't have unlimited resources to tackle investigative challenges associated with older complaints. This change brought about spirited discussion among APA Ethics Committee members, with some arguing that the rare case with well-preserved evidence would go unheard if a statute of limitations was adopted. For example, imagine a boundary-violation scenario in which a former patient produced photographs documenting a vacation he or she took with his or her psychiatrist during the course of treatment. History, however, has shown allegations of unethical conduct preceding the complaint by more than 10 years are a rarity.

In closing, these three new procedural modifications to APA's ethics regulation and education process provide district branches with a more flexible, comprehensive set of tools to handle complaints of unethical conduct, and also put a greater emphasis on the primary goal of the ethics process: education. ■

Custody

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Osher recommended that Congress increase the appropriation for state mental health block grants by 20 percent and mandate that all funds be used to develop family-driven support services and expand effective community-based treatment services for children with psychiatric disorders and for their families.

"Our families also find themselves between a rock and a hard place trying to balance the conflicting mandates, requirements, and demands of several different services or systems," complained Osher.

She recommended that state agencies be required to develop effective interagency working agreements so that services are coordinated and funding is combined from all child-serving agencies. "The goal is for children with mental health problems and their families to have affordable and convenient access to a comprehensive array of supports and services," she said.

Seltzer testified that "Congress has legislation before it that would take two giant steps toward preventing custody relinquishment."

The new legislation should streamline the current system by requiring the creation of a federal interagency task force, as recommended by the GAO, to foster coordination, examine problems of mental health care in the child welfare and juvenile justice systems, and assist states in implementing the grant program.

The Family Opportunity Act (S 622), cosponsored by Sens. Charles Grassley (R-Iowa) and Edward Kennedy (D-Mass.), would expand Medicaid coverage to children whose families would not otherwise be eligible and give states greater flexibility to use the Home and Community-Based Services Waiver to serve children with serious psychiatric disorders.

States Bypass Program

"This critically important tool has not been taken advantage of by most states because of obstacles that Congress has the power to eliminate. Only Vermont, Kansas, and New York have used this waiver," Seltzer told Congress. "They found that the costs of serving these children in the community are half of what would be spent on institutional care."

The Kansas home- and community-based waiver for children with serious psychiatric disturbances has, for example, reduced custody relinquishment and led to positive outcomes in schools, said Seltzer. "More important, the waiver allows families to remain intact."

> **"Our families also find themselves between a rock and a hard place trying to balance the conflicting mandates, requirements, and demands of several different services. . ."**

Federal Law Lags Behind

Federal law has not, however, kept up with changes in practice. The "level of care" a child must meet under the existing statute to qualify for services under the waiver includes care in hospitals, intermediate care facilities, or nursing homes.

Many children are cared for, however, in psychiatric residential treatment centers, an institutional level of care not covered by the statute, Seltzer explained. "Congress needs to modify the statute to allow children receiving or needing inpatient psychiatric services in a residential treatment center to receive services in the community."

Collins vowed to pursue passage of three bills in Congress this year—the Family Opportunity Act, the Sen. Paul Wellstone Mental Health Parity Act, and the Child Healthcare Crisis Relief Act, which includes incentives such as scholarships to help recruit and retain child psychiatrists and mental health professionals.

The legislation cited in this article can be accessed on the Web at <http://thomas.loc.gov> by searching on the respective bill number. ■

Malpractice

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ability market, and the report stated that much of the data necessary for a complete understanding of market trends are not available.

"This lack of data is due, in part, to the nature of NAIC's and states' regulatory reporting requirements for all lines of insurance, which focus primarily on the information needed to evaluate a company's solvency," the GAO stated. "Most insurance regulators do not collect the data that would allow analyses of the severity and frequency of medical-malpractice claims for individual insurer operations within specific states."

In response to the report, Alan Levenson, M.D., president and CEO of Psychiatrists' Purchasing Group, which sponsors the APA-endorsed Professional Liability Insurance Program (PLIP), said psychiatry has not been the focus of controversy around liability premiums and that the profession continues to have among the lowest premiums on average.

Still, he said, the profession is not exempt from what is happening in all of medicine. "Generally, psychiatrists' premiums have not risen with the same speed of [those of] other specialties, but we are feeling the impact of increasing costs across the board," he said. "That has led to two years of premium increases [in the APA-endorsed PLIP] after four years of no increases at all."

Levenson said premiums in the PLIP increased an average of 30 percent in 2002 and 10 percent in 2003. Insurance carriers are dropping out of the market, he added, which also has made it difficult for physicians in all specialties to purchase any malpractice insurance in some states.

Levenson added that the APA-endorsed program remains the largest source of malpractice insurance for psychiatrists, with 7,000 participants.

The GAO report is posted on the Web at <www.gao.gov/new.items/d03702.pdf>. ■