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"See" references appear on pages 5, 18, 20

Assembly Honors Members For Courageous Stand

In addition to presenting its Profile of Courage Award, the Assembly focused much discussion on access obstacles to obtaining psychiatric care and plans to circumvent APA's dual-membership requirement.

BY KEN HAUSMAN

The APA Assembly honored two psychiatrists with its 2003 Profile of Courage Award, which recognizes psychiatrists who have taken financial or professional risks on behalf of patients with mental illness. This year's awards went to former APA president Harold Eist, M.D., and Pittsburgh psychiatrist Daniel Shrager, M.D.

Eist was awarded for his battle with Maryland's medical licensing board over its right to see a patient's records when the patient refused to consent to such a record review. The board attempted, unsuccessfully, to revoke Eist's license but did fine him and report him to the National Practitioner Data Bank. Eist took the board to court over its its demand for the patient records and its sanctions against him, where an administrative law judge ruled in his favor. The board then appealed this decision to a county court, which also ruled in Eist's favor on almost all of the matters at issue. Eist's financial penalty was canceled, and the board was told to revoke its report to the national data bank.

Shrager undertook an expensive battle against a mental health carveout firm that demanded the complete records of five patients whose care it managed for an insurer. It wanted the records as part of its recredentialing process. The company dropped him from its provider panel after Shrager refused to turn over the records without his patients' authorization. Facing a substantial loss of income if he was dropped, he decided to sue the company. The court ruled in his favor, stating that he could edit the charts before turning them over, and said the company could not remove him from its provider roster. Shrager is appealing the ruling that he must turn over redacted versions of the records regardless of whether the patients agree.

APA contributed funds to help both psychiatrists defray the costs of their legal battles.

On one of the more controversial issues to confront the Assembly in quite a while, two district branches' plans to open membership to or create a new affiliation for psychiatrists who would not have to join APA as well received a unanimous negative review from the Assembly Procedures Committee. The committee stated that the proposals would violate APA's Bylaws. (The Assembly was not asked to vote on any issues related to the proposals at last month's meeting.)

please see ***Assembly*** *on page 26*

Daniel Shrager, M.D. (left), and Harold Eist, M.D., pose with their 2003 Profile of Courage awards.

Association News

NYSPA, APA Protest Causes Insurer to Halt Record Audits

Oxford Health Plans announces that it will stop auditing psychotherapists' records for documentation of sessions and develop consistent standards with APA and the NYSPA.

BY CHRISTINE LEHMANN

Oxford Health Plans, a managed care company based in Connecticut, said last month it will stop auditing psychiatrists and mental health professionals for documentation of therapy sessions (*Psychiatric News*, November 7; also see page 3).

Oxford pledged to refund amounts paid by audited psychiatrists and mental health professionals to settle claims of alleged documentation errors and return copies of patient records, according to Oxford spokesperson Maria Gordon Shydlo.

Oxford's chief medical officer, Alan Muney, M.D., said in a press release that the company realized that the variability in documentation of therapy sessions by clinicians was not due to fraud but inconsistent documentation guidelines.

APA and the New York State Psychiatric Association (NYSPA) said they were pleased with Oxford's decision to terminate audits of psychiatrists and mental health professionals.

APA President Marcia Goin, M.D., told *Psychiatric News*, "Oxford will join with APA, NYSPA, and the New York State Society for Clinical Social Work to develop and adopt mutually acceptable standards for office medical record documentation."

She continued, "This is a stunning example of what can be achieved through collaboration and informed aggressive efforts on behalf of our members and their patients."

NYSPA Executive Director Seth Stein, J.D., who hammered out the deal with Oxford, told *Psychiatric News*, "This is a positive development by Oxford. I was particularly pleased that the company agreed to return copies of patient medical records obtained from audited psychotherapists. I insisted on this to avoid potential breaches of confidentiality that can occur when records are simply disposed of without adequate safeguards."

Stein plans to meet again with Oxford representatives about the company's use of the extrapolation method in audits and qualifications of peer reviewers. APA raised concerns about these issues in a November 7 letter to Oxford President and CEO Charles Berg.

The American Psychoanalytic Association and the American Psychological Association wrote Berg in October about similar concerns.

"We also want to ensure that if Oxford uses the documentation standards as a measure of compliance in future mental health care audits, [the company should] disclose the purpose and protocol for audits and any payment recovery plan to psychotherapists before they sign the contract," said Stein.

APA's November 7 letter to Oxford is posted on the APA Web site at <www.psych.org/news_room/press_releases/CE_letter.cfm>. ■

Low-Income Patients Benefit Most From Medicare Prescription Law

The Medicare reform package includes coverage of individuals eligible for both Medicare and Medicaid—a category that includes many psychiatric patients. The bill also replaces a scheduled decrease in 2004 physician payments with a 1.5 percent increase.

BY MARK MORAN

Congress approved an historic and controversial new Medicare reform package intended to modernize the 38-year-old entitlement program and contain costs by making it more competitive, while offering for the first time a benefit providing coverage for prescription drugs.

After weeks of speculation about whether the hotly contested legislation would emerge at all, a House-Senate conference committee forged an agreement just a week before the Thanksgiving recess, followed in rapid succession by House and Senate approval. President Bush signed the legislation in early December.

The legislation initiates a drug benefit for Medicare beneficiaries in 2006. The agreement provides protections for low-income individuals, including coverage of those eligible for both Medicare and Medicaid—a category encompassing many psychiatric patients.

The bill does not include mention of psychotropic drugs, but APA and the National Alliance for the Mentally Ill were successful in persuading legislators to include nonbinding "report" language—provisions in the explanatory report that accompanies the legislation—protecting beneficiary access to psychotropic medications. These include but are not limited to those used to treat specific mental illnesses such as schizophrenia, attention-deficit/hyperactivity disorder, bipolar disorder, and depression.

The bill also blocks a scheduled decrease of 4.5 percent in physician payment for 2004, replacing it with a 1.5 percent increase and providing another 1.5 percent increase in 2005. APA, along with the American Medical Association and more than 100 other national medical specialty societies and state medical societies, strongly lobbied for the change.

APA also lobbied for ending the program's historic 50 percent coinsurance for outpatient psychiatric services. While that provision remains in effect, APA secured a letter from more than 40 members of the House of Representatives in support of phasing out the discriminatory copay, according to APA's Division of Government Relations.

The conference agreement received the endorsement of the AARP. "This bill will help millions of people, especially those with low incomes and high drug costs," the AARP stated. "It will strengthen Medicare by adding this long-overdue benefit and preserving the basic structure of the Medicare program."

Yet the bill has also been the subject of heated criticism—that it adds layers of complexity to the program with little guidance for beneficiaries on how to navigate the new benefits, that the actual benefits will be far less substantial than many beneficiaries expect and need, and that privatization of the program will disrupt the universality of costs and benefits that has been the hallmark of Medicare.

Also controversial is a provision in the law that allows importation of prescription drugs from Canada—and from nowhere else—but with the caveat that imported drugs must be certified as safe by the secretary of Health and Human Services.

The safety certification is considered "the poison pill" of the provision, because no HHS secretary—including current secretary Tommy Thompson—is likely to commit to guaranteeing safety of imported drugs.

please see ***Medicare*** *on page 27*

The Highlights

Rx Drug Discount Card

- Medicare-endorsed prescription drug discount cards will be available to all beneficiaries April 2004.
- HHS estimates savings between 15 percent and 24 percent per prescription.
- Low-income beneficiaries receive $600 of assistance per year for 2004 and 2005.

Prescription Drug Benefit Initiated in 2006

Standard benefit

- $250 deductible
- 75 percent coverage up to $2,250
- $3,600 out-of-pocket catastrophic coverage limit
- $35 average monthly premium

Private health plans

- Beneficiaries have access to at least one prescription drug plan and one integrated private health plan with prescription drug benefits in each medical service area.

Low-Income Assistance

- Individuals eligible for both Medicare and Medicaid have access to the Medicare drug benefit.
- Cost-sharing and premium assistance for those up to 150 percent of poverty level with no gap in coverage.
- Dually eligible individuals below 100 percent of poverty level pay $1 for generics and $3 for brand name.
- Below 150 percent of poverty level, individuals pay $50 deductible and a sliding-scale premium.

APA Fighting Fires

BY MARCIA GOIN, M.D.

This year many of our colleagues felt the heat of a dangerous fire when Oxford Insurance Company demanded they turn over their psychotherapy notes to verify the authenticity of reported billable hours. The story broke on September 27 with the *New York Times* headline: "Insurer Seeks Return of Fees for Therapy." The *Times* reported that the insurer, Oxford Health Plans, had audited hundreds of psychiatrists, psychologists, and social workers; deemed their notes as inadequate documentation of the sessions; and demanded repayment of thousands of dollars from each provider *(Psychiatric News*, November 7).

Shocked by this revelation, I was heartened that the *New York Times* on October 4 published my letter to the editor, which addressed the outrageous breach of patient confidentiality associated with Oxford's actions. In my letter I stated:

"Imagine the chilling effect on the open expression of one's thoughts and feelings during a psychotherapy session if it is understood that the therapist is taking verbatim notes, notes that will be reviewed by one's insurer. Such intrusions destroy the needed doctor-patient therapeutic commitment to privacy.

" 'Reason tells us that psychotherapists and patients share a unique relationship, in which the ability to communicate freely without the fear of public disclosure is the key to successful treatment.' This is the wording of the Supreme Court decision in *Jaffee v. Redmond* (1996).

"The Department of Health and Human Services appreciated this reality and as a consequence provided special privacy protection for psychotherapy notes in the Health Insurance Portability and Accountability Act regulations. Oxford Health Plans ignores these rulings."

Working to fight this fire, APA's Division of Healthcare Systems and Financing, directed by Sam Muszynski, joined forces with the New York State Psychiatric Association (NYSPA) and its executive director, Seth Stein, and president, Dr. Barry Perlman, who had already begun to investigate and counterattack.

On November 7 APA sent a letter to Charles Berg, president and CEO of Oxford Health Plans, expressing the outrage of our organization at the company's egregious actions. The letter stated that we could not determine Oxford's documentation standards, we were unable to discover any policy basis for the company's statements on the documentation of psychiatric services, and we maintained that psychiatrists cannot be penalized for failing to comply with standards that do not exist. We also questioned the qualifications of those conducting the reviews.

In summary we said that Oxford audits raised serious issues with regard to these points: the absence of a documentation standard of review, the qualifications of the reviewer, the lack of appropriate remedial action, and the preservation of patient confidentiality. We respectfully requested an opportunity to meet.

Meetings between Oxford, APA, and NYSPA occurred. On November 25 Oxford Health Plans issued a press release announcing that it was terminating all current audits of psychiatrists in New York, New Jersey, and Connecticut relating to documentation of services. The company also agreed to refund any sums repaid by providers who settled with Oxford and to return all copies of patient records submitted pursuant to the audit.

Quite a timeline! It is a stunning example of how collaboration, along with vigorous, informed, aggressive efforts can result in an outcome of major significance for our patients and our profession.

Traveling the country as your president and attending various meetings, I am frequently asked, "What does APA do for me? Why should I belong?"

I talk about APA as the face to the world of our respected medical specialty and how it supports the high clinical and ethical standards of our profession. To this end, it is a source of our influence on the social and political structures that have great impact on our daily lives and practice. It additionally provides multiple opportunities for lifelong learning and essential practice tools and updates as represented by journals, practice guidelines, and professional meetings. Often I can't resist also saying, however, "Do we ask the fire department what it does for us? If our house hasn't caught fire recently, do we wonder why we should pay to support the fire department?"

This fall there were dangerous wildfires in Southern California. Firefighters came from all over California and the neighboring states to help end the devastation. They have returned home now but are poised to go again whenever and wherever they are needed. I think of certain aspects of the value of APA in a similar manner: working collaboratively with district branches to fight psychologist prescribing, providing public education to end stigma, working for parity, and demonstrating the problems with access and the criminalization of people with mental illness. The benefits of these dedicated advocacy efforts are not always as immediately visible. They are, however, integral to what makes our organization strong. ■

Member Benefits and Services That Save You Money

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

As an APA member, you benefit from more than lifelong-learning opportunities at significant savings; free subscriptions to the *American Journal of Psychiatry*, *Psychiatric News*, and *Psychiatric Services;* strong advocacy at the local, state, and national levels on mental health issues; and professional practice tools such as the Managed Care Help Line and *CPT* Coding Services.

Did you know that you can also take advantage of the following members-only programs that provide significant savings for you and your practice?

• **MBNA Credit Cards** offers APA members an array of products that help you finance business and personal expenses, generate interest income, and increase your cash flow. You can also earn frequent-flyer points.

• **The APA Job Bank** has recently expanded its resources to provide benefits to members at all levels of practice, from medical students to senior-level psychiatrists. New career development resources include a self-assessment questionnaire, sample CVs and cover letters, and tips on conducting an effective job or practice search. Whether you're looking for a talented psychiatrist or the right psychiatric opportunity, start your search at <www.psych.org/jobbank>, the best resource for psychiatric job placement.

• **The Psychiatrists' Professional Liability Insurance Program,** the APA-endorsed professional liability insurance program, provides medical malpractice insurance for psychiatrists. Participants have access to the toll-free Risk Management Consultation Service and risk management seminars and articles. Coverage includes forensic psychiatric services and an administrative defense benefit. Discounts are available for groups; early career, child and adolescent, and part-time psychiatrists; and moonlighting members-in-training. The insurance program is administered by Professional Risk Management Services (PRMS). For additional information, call PRMS at (800) 245-3333 or visit the PRMS Web site at <www.psych program.com>.

• APA members can **rent cars** at substantial discounts with Alamo, Avis, Hertz, and National car rentals.

• **The Capital for Knowledge Program** is designed for APA members and their families to meet the rising costs of education (for example, private school, college, postgraduate degrees). APA members are eligible to borrow up to $25,000 a year, including up to $5,000 for a personal computer.

• APA members can save up to 50 percent off regular **magazine-subscription rates** for office and personal use. The same low rates apply to new subscriptions and renewals. Join hundreds of your colleagues who use this valuable program by signing up today.

• **Grande Financial Services Inc.** provides a comprehensive program to assist APA members in meeting their short- and long-term investment and retirement goals.

• APA members can obtain practice-related legal advice on managed care contracts, subpoenas, group practice, malpractice, risk management, and third-party reimbursement from **APA's Legal Consultation Plan.**

• **American Psychiatric Publishing Inc. (APPI)** offers significant discounts to APA members. General members receive a 10 percent discount on APPI books and journals, while members-in-training are eligible for a 25 percent discount when they purchase books and journals from the APPI Web site at <www.appi.org>.

Look for other APA member programs and discounts for you and your practice to be added in the future. More information on APA member benefits and services can be obtained by calling the APA Answer Center at (888) 35-PSYCH or (703) 907-7300 or by visiting the Web site <www.psych.org/members/benefits/memservices.cfm>.

Feel free to e-mail your questions, comments and suggestions to me at medicaldirector@psych.org. ■

Professional News

NMHA President Wins Wellstone Award

Eliot Sorel, M.D. (left), presents the 2003 Sen. Paul and Mrs. Sheila Wellstone Mental Health Visionary Award of the Washington Psychiatric Society (WPS) to **Michael M. Faenza,** president and CEO of the National Mental Health Association (NMHA). At right is **Jeffrey Akman, M.D.,** president of the WPS. Sorel chaired the WPS committee that selected the winner.

WPS chose Faenza from a pool of nationally distinguished mental health leaders because he stood out as a "brother at heart with Sen. and Mrs. Wellstone" and shared the late senator's vision and drive to make mental health care available to all those who need it. Specifically, Faenza worked tirelessly alongside Wellstone toward ending insurance discrimination against people with mental disorders.

With more than 25 years of experience in the mental health field, Faenza has spent the past decade focusing on legislative advocacy and improving America's commitment to helping people with mental illnesses through his leadership at the NMHA.

"Sen. Wellstone was a committed, concerned, and passionate individual," said Faenza. "I am humbled to be recognized for sharing the ideals of one of the finest elected officials I have ever known."

The NMHA is the country's oldest and largest nonprofit organization addressing issues related to mental health and mental illness.

Psychiatrists, Advocates Secure Final Victory in Vermont

After a grueling two-year struggle fraught with scandal, resignations, and investigations, Vermont's largest health care facility looks forward to a new inpatient mental health unit.

BY JIM ROSACK

A coalition of mental health advocates, patients, and clinicians are celebrating state regulators' final approval of plans mandating an integrated, state-of-the-art, inpatient psychiatric unit at Fletcher Allen Health Care in Burlington, Vt.

Nearly two years ago, mental health advocates in Vermont had no idea what they were getting themselves into. As psychiatrists, psychologists, counselors, advocates, and patients, the unlikely coalition of concerned citizens simply knew they could not sit silently on the sidelines as the state's largest medical center—literally as well as figuratively—marginalized patients with mental illness *(Psychiatric News*, May 18, 2001; November 16, 2001; June 7, 2002; June 21, 2002; September 20, 2002). The hospital was planning to relocate its inpatient mental health unit to a setting several miles removed from the hospital's main campus, caring for psychiatric inpatients in what amounted to a "separate but equal" facility.

Adopting the slogan "Nothing About Us, Without Us," the coalition members proved that, working together, they could take on one of New England's leading health care providers and force it to do what they believed was right for psychiatric inpatient care.

The group, led by members of the Vermont Psychiatric Association (VPA), set out, along with others, to convince hospital administrators, the community, and state regulators that the proposal for a separate mental health inpatient unit was not appropriate or acceptable.

Collaboration Redefined

The coalition's impact became significantly greater than ever imagined in a collaboration that would wield considerable influence and power. Along the way the coalition exposed wrongdoings that led to the resignations of hospital administrators, a gutting of the facility's board of trustees, state and federal criminal investigations that involved charges of lying under oath to state regulators, falsified documentation, and fraudulently obtained state-backed financing for the hospital's massive renovation and expansion, known as the Renaissance Project.

By the end of the fight, the hospital made limited admissions of wrongdoing and paid a fine of $1 million to the state and federal governments.

Moreover, a particularly strong patient advocate and leader in the mental health coalition became known as a local hero, winning election to the state legislature. And four prominent psychiatrists on staff at Fletcher Allen and members of the faculty of the University of Vermont School of Medicine were recognized with APA's Profile of Courage Award for their efforts to safeguard their patients' care *(Psychiatric News*, December 6, 2002). The four provided crucial testimony to state regulators amid threats of being fired for speaking out against the hospital's plan.

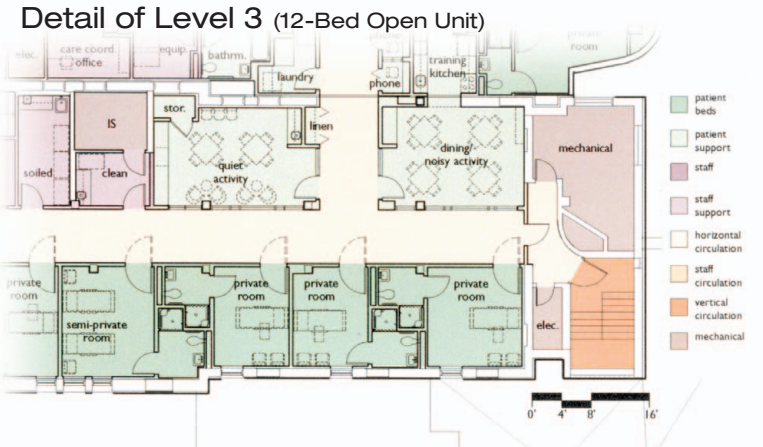
Future Begins With Approval

In an 89-page decision, regulators gave the hospital the final go ahead to build the hospital's massive, $365-million project.

More than 15 of those pages concern mental health services at the hospital. State regulators ordered the hospital to begin immediately an analysis of conditions in the current psychiatric inpatient unit and to collaborate with members of the mental health coalition to identify and undertake immediate improvements. The state also ordered the hospital to consult regularly with the coalition to finalize plans for a new, $17 million inpatient unit that will be housed on two floors of completely renovated space in an existing building on the hospital's campus (see diagram). The hospital was ordered to submit final plans for improving the old unit and final designs for the new unit, including clear indication of "the recommendations as to the plan of each member of the Mental Health Task Force." The plans must address patient safety, improved access to outdoor space, and privacy.

please see ***Vermont*** *on page 6*

Detail of Level 3 (12-Bed Open Unit)



Public Gets the Message: Pain Not Just Physical

A major goal of a public education campaign on the link between depression and physical pain is to encourage Americans to talk to their doctors about their mood and painful physical symptoms.

The American Psychiatric Foundation is among the physician and advocacy groups sponsoring a new public service campaign to educate Americans about an often underrecognized side of depression: physical pain.

"One aspect of depression that is highly prevalent but not understood by the public is the relationship between aches and pains and depression," said John S. McIntyre, M.D., a member of the Board of Directors of the American Psychiatric Foundation and a past president of APA.

"Many people don't realize the significant overlap between physical and emotional symptoms."

The campaign features the headline "Your Body May Know You're Depressed Before You Do." It is now appearing on billboards and transit advertising in four cities—Washington, D.C., Philadelphia, Chicago, and Atlanta—and will run for a minimum of three months.

The other campaign sponsors are the National Pain Foundation and Freedom From Fear, a patient advocacy organization.

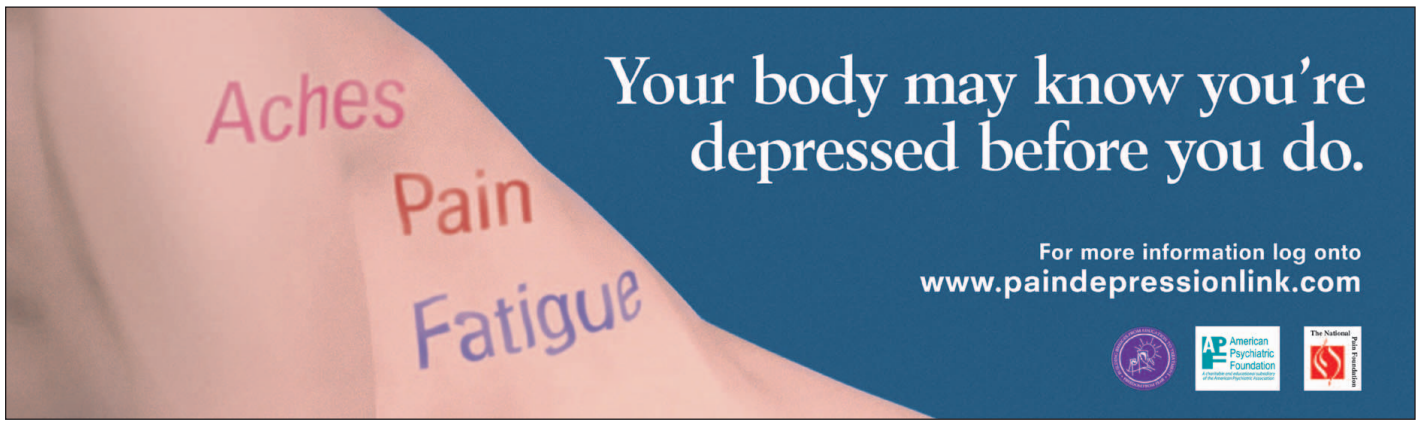
Depression currently affects more than 19 million adults in the United States, and 57 percent of Americans have suffered from chronic pain.

The relationship between physical pain and depression manifests itself in many aspects of patients' lives. Results of a survey conducted last May by Freedom From Fear during its National Anxiety Disorders Screening Day showed that 40 percent of respondents said that physical symptoms of depression and anxiety disrupt their work moderately, mostly, or extremely; 43 percent said that physical symptoms disrupt their social life moderately, mostly, or extremely; and 47 percent said that physical symptoms disrupt their family life/home responsibilities moderately, mostly, or extremely.

Recent research suggests that complete remission of depression is most likely to occur when all emotional and physical symptoms are eliminated.

"It is critical that people understand the relationship between pain and depression so that if they are suffering, they can talk to their physician about both their mood and their painful physical symptoms. This will give them the best chance for getting effective treatment," said Rollin "Mac" Gallagher, M.D., M.P.H., a professor of psychiatry, anesthesiology, and public health at the Medical College of Pennsylvania and a member of the executive committee of the board of the National Pain Foundation.

More information about the campaign is posted on the Web at <www.paindepressionlink.com>, which provides links to the sites of the three participating organizations. ■



Vermont

continued from page 5

The approval is clearly a sweet victory for the coalition's varied members.

"It is a profoundly exciting experience to see the enormous power of a community that stretches from the consumer to the advocate to the practitioner," Ken Libertoff, director of the Vermont Association for Mental Health, told reporters.

David Fassler, M.D., APA trustee-at-large and state legislative affairs representative for the VPA, noted that "the process wouldn't have worked so well without a team of dedicated consumers, advocates, and providers who were determined to hold folks accountable and to do whatever was necessary to ensure ongoing access to appropriate care for people with psychiatric illnesses." ■

Canadian Exports Benefit Caribbean Islanders

Leaving "psychiatric footprints in the sand" aptly describes a program that is making a difference in the lives of people with mental illness on two Caribbean Islands.

BY JOAN AREHART-TREICHEL

Everybody knows the expression "trading guns for butter." But how about "trading rum for psychiatrists"? This notion may sound outlandish, yet there is really something to it.

During the 18th century, the sister Caribbean islands of St. Kitts and Nevis exported rum to the Canadian maritime province of Nova Scotia. Today the psychiatry department at Dalhousie University in Halifax, Nova Scotia, is exporting a handful of senior residents to St. Kitts and Nevis for three- to six-month periods to improve the care of mentally ill people there.

The program is the brainchild of Stan Kutcher, M.D., head of the division of international psychiatry at Dalhousie. As Kutcher explained at the recent annual meeting of the Canadian Psychiatric Association (CPA) in Halifax, the reasons for the program are many: The world is growing smaller; Canadians are "an incredibly lucky, wealthy group of people"; and Canadian psychiatrists have something to offer mentally ill people in developing countries.

The reasons why he decided to target St. Kitts and its smaller sister island, Kutcher added, are because Nova Scotia and these islands have had a special relationship for many years, and these islands—with their lush, mountainous beauty and tropical climate—would be enticing to psychiatric residents.

Still, working there as a psychiatrist is "by no means like participating in Club Med," Kutcher noted. No one would agree more than Sonia Chehil, M.D., one of the four residents who has taken part in the program since it was launched in 2000. (She participated in 2001.)

Health System Is Rudimentary

"Even though St. Kitts and Nevis are English speaking, there is a huge cultural difference between them and Canada and between them and the United States," Chehil told *Psychiatric News*. "I think a lot of people in Canada, as in the United States, see the Caribbean as being relatively developed. In fact, its institutional health structures are quite rudimentary. So that was one shock for me."

St. Kitts and Nevis have a population of about 44,000 people, yet the islands have only 12 psychiatric beds in a general hospital, a handful of community clinics, and a reconverted stable to house patients with chronic mental illness, she noted.

Another shock was that only one other psychiatrist worked on St. Kitts and Nevis during the six months that Chehil practiced there. "That was overwhelming—so many patients to see!," she exclaimed.

Then there was a scarcity of psychotropic medications, especially of the newer ones. Even those from which she could usually choose were sometimes out of stock. "For instance, I could put a patient in the hospital on a medication, and he or she would get better," she said, "but suddenly there wouldn't be any medication anymore, and the patient would, of course, relapse."

Hexes Thought to Cause Illness

Still another surprise for Chehil was that the islands' citizens often believe that mental illness was caused by the person being hexed or possessed by a spirit. Such perceptions often deter the islanders from seeking modern psychiatric care, she learned.

Sonia Chehil, M.D.: "All of us residents saw patients who got better because of our care."

Finally, stigma against mentally ill residents is enormous on the two islands, Chehil discovered. As a result, patients are often discouraged by their families from seeing a psychiatrist and from taking psychiatric medications. "So it was very difficult to treat people adequately," she lamented.

Nonetheless, "all of us residents saw patients who got better because of our care," Chehil said. "Just recognizing that the patients could be well enough to reconnect with their families or have some kind of vocation was a real revelation, not just to the patients, but to the nursing staff and hospital administrators."

"What we have also seen," she explained, "is that the nurses we worked with were very enthusiastic about learning more about mental health, and that as each of us residents has mentored the nurses, their skill sets have grown proportionately. That is a significant contribution that will continue to grow as we send down more residents."

And, indeed, more residents will be coming, Kutcher said at the CPA meeting. In fact, psychiatry residents from other Canadian universities are welcome to participate in the program, and it is being expanded to send residents to another Caribbean island—Tobago.

Dalhousie is the only Canadian university with such a program, Kutcher pointed out. However, two other Canadian universities—McGill University and the University of British Columbia—may be setting up similar initiatives. Also, the University of Toronto is sending psychiatry residents to Ethiopia to teach psychiatry residents there. ■

Cultural Awareness Critical To Post-Disaster Care

Psychiatrists providing services to culturally diverse populations in disaster recovery missions may be more successful if they work closely with spiritual leaders and existing support networks in the community.

BY EVE BENDER

When disaster strikes, the ways in which people grieve and work toward recovery may be influenced by their cultural backgrounds, according to experts in disaster mental health who spoke at APA's 2003 Institute on Psychiatric Services in October in Boston.

Just weeks after thousands perished in the terrorist attacks on the World Trade Center buildings and New York City residents were sickened by anthrax spores, New Yorkers were hit with another disaster—the crash of Flight 587.

The flight took off on the morning of November 12, 2001, from John F. Kennedy International Airport bound for Santo Domingo in the Dominican Republic. Minutes later, it crashed into a Queens neighborhood, killing all 260 people on board and five on the ground *(Psychiatric News*, December 7, 2001).

Mass Chaos Ensued

Anthony Ng, M.D., who was then medical director of Disaster Psychiatry Outreach (DPO), worked with the New York City Department of Mental Health to aid surviving family members. Ng is now chair of APA's Committee on the Psychiatric Dimensions of Disasters.

Less than an hour after the crash, he arrived at the place where family members of the victims were told to congregate—the Ramada Plaza Hotel, which is close to the airport.

Hundreds of family members who had just bade their loved ones farewell at the airport converged on the Ramada, Ng said, before the family assistance center could be fully staffed and organized.

In a scene he described as "chaos," hotel guests watched as an influx of anguished family members poured through the hotel's entryway, surrounded by members of the media.

Many of the family members spoke only Spanish, Ng said, yet there were few translators on hand.

"The wailing and screaming of some were tremendous and quickly affected other family members," he said, especially when the passenger list was read aloud.

Paramedics and mental health professionals on the scene were overwhelmed "by the extraordinary nature of this grief," Ng added, and physicians dispensed anxiolytic medications to some family members to reduce their acute level of distress. Ideally, he said, the family assistance center should have been set up so that each family would have a private space in which to grieve.

Anthony Ng, M.D., chair of APA's Committee on the Psychiatric Dimensions of Disasters, and Patricia Mendoza Bonewitz, Ph.D., a disaster mental health consultant, shared insights at APA's 2003 Institute on Psychiatric Services in Boston on how to help minority populations cope after disaster strikes.

Spirituality Important

After a memorial service a week later, family members were bused to the crash site. "You could still smell the jet fuel and see a crater in the ground," Ng recalled.

Many family members were distraught, and although psychiatrists and mental health professionals were available to offer support, Ng said it is best for a spiritual leader such as a priest to approach grieving family members first.

"Then, if this distress persists," Ng said, "we provide them with mental health care."

A few days after the crash, the family assistance center was moved to midtown Manhattan. As family members drifted in and out, Ng observed that Latinos who had lost loved ones on Flight 587 "relied on spiritual counseling first; mental health counseling came second."

Because spirituality is important to so many Dominicans, Ng and his colleagues worked closely with spiritual leaders to help the family members better cope with and eventually recover from the tragedy. "This is a resilient group," he said.

Cultural Liaisons Build Trust

Just hours after 12 jurors in Sylmar, Calif., read their verdicts on April 29, 1992, clearing four white police officers of the beating of black motorist Rodney King, Los Angeles and surrounding areas erupted in three days of violence.

The toll from the riots was devastating: more than 50 people were killed, more than 4,000 people were injured, 12,000 people were arrested, and fires and looting resulted in property damage of a billion dollars.

Psychologist and disaster mental health consultant Patricia Mendoza Bonewitz, Ph.D., worked with the Los Angeles County Department of Mental Health to provide mental health services to Los Angeles residents during and after the riots.

South-Central Los Angeles, where much of the rioting took place, had the feel of a war zone, she said. For the most part, the residents in this part of Los Angeles are low-income African Americans and Latinos who could not afford to replace damaged or stolen property.

"The level of personal loss was huge," she said.

"Among some Latinos and African Americans, there is a distrust of government-run services," said Mendoza Bonewitz. To earn the trust of residents in need of help, she spent extra time establishing rapport with them.

"Revealing something of yourself may break down barriers and help people talk to you more comfortably," she told attendees.

To reach as many people as possible, Mendoza Bonewitz found it helpful to "find sites in the community where people were most comfortable and provide mental health and disaster relief services there."

She found herself meeting with and counseling residents in beauty shops, malls, and churches, she said.

Forming a liaison with a "cultural broker" who already has the trust of a multicultural community is also helpful, she added. In this case, Mendoza Bonewitz and her colleagues worked closely with the pastor of the AME church in South-Central Los Angeles. "Many of our disaster-related services were held at this church," she added.

In Long Beach, an hour south of Los Angeles, a Buddhist priest and a Samoan tribal chief worked with disaster-recovery officials to reach residents who had been affected by rioting there, Mendoza Bonewitz said.

She advised attendees wishing to get involved in disaster recovery to work with community agencies. "The work we do as psychiatrists, psychologists, and mental health workers is time limited, but the natural support networks in the community are already providing services to these people." Outside assistance should focus on strengthening those services, she said. ■

Disaster Response for Native Americans Complicated by History, Money

Understanding the cultural backgrounds of American Indians is essential to helping them recover after disaster strikes.

BY EVE BENDER

Poor disaster preparedness, a lack of resources for rebuilding, and a legacy of "collective grief" make disaster recovery especially difficult for American Indians.

That was the message delivered by Marilyn Shigetani, M.A., M.P.H., to attendees at a session on the cultural aspects of disaster mental health at APA's 2003 Institute on Psychiatric Services in Boston in October.

Shigetani, an American Indian, is a Federal Emergency Management Agency (FEMA) liaison to Region IX, which encompasses California, Hawaii, and the U.S. Pacific islands.

When a levee broke near the small town of Wakpala, S.D., in 1997, there were no sirens and no emergency broadcasting system to warn members of the Standing Rock Sioux tribe to evacuate ahead of the impending flood, Shigetani said. Instead, a town crier of sorts walked through the reservation telling people to evacuate.

"In Indian country, there are no shelters in place when disaster strikes," she said, "so evacuating an entire community becomes problematic."

Tribal government officials guided the displaced families to a village that was miles away. When they returned, 27 families discovered that the flood had destroyed their homes.

Disaster struck again two years later. In 1999 tornadoes tore through southwestern South Dakota, causing significant damage to the Pine Ridge Indian Reservation. This time, as many as 200 Sioux families lost their homes, Shigetani said.

The Pine Ridge reservation depended on money from FEMA to rebuild, she added, because "there were no funds set aside for disaster recovery." A shortage of funds is only one of many obstacles to disaster recovery for American Indians, she said.

The numerous tribulations of American Indians over the past couple of centuries make recovery from disasters such as floods and tornadoes in the present seem like an uphill battle.

"We have collective grief of many treaties broken and many sad memories. We lack trust in outsiders and even other Indians. We are a race that has been separated, and we feel disempowered. Then we further victimize ourselves—we don't need floods or tornadoes to feel like victims," Shigetani said.

In addition, admitting the need for mental health services is especially problematic for American Indians, such as members of the Standing Rock Sioux tribe. "By seeking help for the white man's understanding of mental health problems," she said, tribal members would believe this "shows a weakness in the community. . . .What we have done is fail each other by not meeting the needs of our people."

Shigetani dispensed the following advice to attendees about assisting American Indians in disaster recovery: One must first seek an invitation from the tribal government before one can help, she said. Introductions are important, too. Many times, she observed, people introduce themselves by stating their names and the agency they represent.

"Now you are an institution—not a person—coming to help," she observed. "We've had some experiences with institutions, and there are some issues there. . . . To us, it's not who you represent that is important, but who you are."

In addition, American Indians want to know how committed outsiders are to helping them cope with disaster. "How long are you going to be around?" Shigetani asked. "Are you going to assist us through the transition to recovery, or are you going to spend a couple of weeks and then get out of town?"

She advised attendees that they should be "committed for the long haul," or at least work with staff from local mental health or disaster-relief organizations or both to ensure that their efforts are carried out. ■

Psychiatrists Bring Expertise To Primary Care Setting

Instead of being exposed to acutely psychotic patients on an inpatient unit, family medicine residents in one training program are gaining relevant practice experience with primary care patients.

BY EVE BENDER

Family medicine residents at the University of Florida Health Sciences Center are working alongside psychiatrists in a busy primary care clinic so they can better identify and treat patients with mood and anxiety disorders in their own practices once they graduate.

"Sixty percent of people with depression in this country go to a primary care doctor initially for help," said Richard Christiansen, M.D., who spoke at APA's 2003 Institute on Psychiatric Services in Boston about the importance of teaching psychiatric skills to primary care physicians.

Christiansen is an associate professor of psychiatry and director of the community psychiatry program at the University of Florida College of Medicine in Jacksonville.

Stigma may keep the majority of people who think they have mental health problems away from psychiatrists, while others may not recognize that their symptoms are part of a mental illness, he said.

Some patients with an undiagnosed anxiety disorder, for instance, may go to their primary care doctor with somatic complaints. "They tell their physicians, 'I have this muscle tension, I can't sleep, and I'm stressed,' " said Christiansen.

Unfortunately, their primary care physicians may not recognize an underlying mental health problem. "Primary care physicians need to be trained in how to diagnose mental illness adequately, initiate treatment, and monitor people over time," Christiansen said. "Early identification and treatment are crucial for the patient" in terms of recovery, he added.

In many residency training programs, nonpsychiatry medical residents are trained to work on inpatient psychiatry units, an acute setting in which residents are trained in emergency, crisis-oriented psychiatry.

"They learn how to titrate medications quickly and do brief, crisis-oriented evaluations," said Christiansen, in addition to "discharging patients back into the community in a partially stabilized manner." At the University of Florida's Community Health and Family Medicine Clinic in Jacksonville, however, family medicine residents are learning how to evaluate and treat patients with mental health problems in primary care settings.

The clinic was established in 2001 through a collaboration between the university's community psychiatry program and its division of community health and family medicine, Christiansen said.

Patients who come to the clinic first meet with a primary care doctor, and if he or she suspects that there is a psychiatric component to the patient's health problems, the doctor recommends that the patient schedule an appointment with Christiansen, who is the sole psychiatrist at the clinic. They don't have to go far—Christiansen's office space is adjacent to that of the primary care physicians.

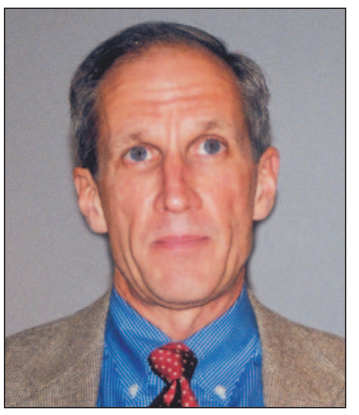
PGY-2 family medicine residents then work with these patients under Christiansen's close supervision. During the month-long training, residents learn how to conduct a psychiatric evaluation, for instance.

Christiansen said he provides immediate feedback to residents on their ability to form an alliance with patients and answer questions that come up during the interview process.

At the end of each psychiatric evaluation, Christiansen, the resident, and the patient discuss treatment options, follow-up visits, and psychosocial issues that need to be addressed.

Patients receive follow-up treatment at the clinic, including medication, psychotherapy with a Ph.D.-level psychologist who works at the clinic, or both.

Of the 10,000 patients who come through the primary care clinic each year, about 1,000 require mental health services, Christiansen said. About 80 percent of that group are diagnosed with mood and anxiety disorders. "These are the folks [whom the primary care residents] are most likely to see later on in their practices," he added.



Richard Christiansen, M.D.: "Primary care physicians need to be trained in how to diagnose mental illness adequately, initiate treatment, and monitor people over time."

Although he has received positive feedback about the utility of the training from many of the family medicine residents he has supervised, Christiansen said he would like to develop some longitudinal measures to determine how the training impacted the residents' practices after they graduate and are practicing in the community. ■

Congress's Psychiatrist Still Says Single-Payer System Needed

Nearly 10 years ago, Rep. Jim McDermott, M.D., warned that doctors were about to become "serfs of the insurance industry" and argued for a single-payer system of financing health care. He continues that advocacy in response to the failures of managed care.

BY KATE MULLIGAN

Rep. Jim McDermott (D-Wash.), the only psychiatrist in Congress, takes no pleasure in his prophetic abilities. In 1994 he warned APA members and anyone else who would listen about the potential hazards of managed care and urged support for a single-payer system of financing health care.

McDermott told the audience at the William C. Menninger Memorial Convocation Lecture at APA's annual meeting that year, "The wildfire of managed care competition is sweeping across the landscape of medical practice." He also quoted health care economist Uwe Reinhardt, who had predicted that in five years all doctors would be "serfs of the insurance industry."

Earlier that year, McDermott, the only psychiatrist in Congress, urged APA's Board of Trustees to support single-payer legislation, arguing, "[I]t is the only way you are going to have any chance in the future to have a say about health policy."

In a recent interview with *Psychiatric News*, he discussed the political and economic factors that affect the current debate about health care reform and his single-payer legislative proposal.

"Everywhere you turn, there is another problem," McDermott said. "The same tide that led to managed care in the early 1990s is building."

Rep. Jim McDermott, M.D. (D-Wash.), calls the recently passed Medicare legislation a "turkey" because of its diversion of funds that could have helped seniors rather than pharmaceutical and insurance companies.

The number of people without health insurance is increasing, as is the cost of health care. Now, however, little or no hope remains that managed care can solve the

please see ***McDermott*** *on page 18*

Senators Intervene In VA's Plans For MH Care

BY KATE MULLIGAN

Sens. Hillary Rodham Clinton (D-N.Y.), Mike Enzi (R-Wyo.), and Charles Schumer (D-N.Y.) have secured an agreement from the Senate's Subcommittee for Appropriations for the Department of Veterans Affairs (VA) about key issues affecting mental health in implementation of the Capital Asset Realignment for Enhanced Services (CARES) Plan.

VA psychiatrists and mental health advocates expressed concern that the VA was using a flawed planning model to determine the need for mental health services for the next two decades and that hospitals and other facilities would be closed without sufficient planning *(Psychiatric News*, November 21).

According to the "Senate Record" for November 17, Clinton said, "We understand that you [Senate managers for the legislation] are committed to pursue language in the Conference Report. . .that would urge that no closures or reduction in long-term care, domiciliary care, and mental health care services would take place until the full analysis is completed. The language would also require the VA to submit updates on their progress in this analysis to the appropriate committees."

Schumer said that the managers had agreed to present language that would "recognize the benefits of and the need to have CARES-related hearings within 30 miles of all facilities facing closure or a reduction in services, as well as the importance of veteran participation at these hearings."

At a meeting on November 12 on mental health issues, VA Undersecretary for Health Robert H. Roswell, M.D., assured APA Medical Director James H. Scully Jr., M.D., and Acting Director of Government Relations Eugene Cassel, J.D., that the VA recognizes that the planning model underestimates future need for mental health services and that adjustments will be made at a later date.

Final recommendations of the CARES Commission are due to VA Secretary Anthony J. Principi sometime this month. ■

High-Cost Medical Advances Need to Prove Value

Although advances in medical technology have produced substantial benefits, it is possible that a considerable amount of money is being spent on new technologies that are not cost-effective.

BY MARK MORAN

Increases in the availability of certain kinds of medical technology—particularly freestanding diagnostic imaging and high-technology cardiac care—are linked to substantially higher spending.

The study, which appeared in the November 5 *Health Affairs* journal, confirms previous research showing that advancing technology is a major driver of health care costs. But the *Health Affairs* study is the first to provide evidence of direct usage and cost increases related to specific new technologies. In some cases technologies add millions of dollars a year to health care costs.

The study was conducted by researchers at Stanford University and the Analysis Group, a business and financial consulting firm in Boston. The study was supported by Blue Cross and Blue Shield Association (BCBSA).

"As we are confronted with large and seemingly incessant increases in cost, we have to pay attention to what we are spending money on," said study co-author Laurence Baker, Ph.D., an associate professor of health research and policy at Stanford University. "Although advances in medical technology have produced large benefits in some cases, it is also quite likely that we are spending a considerable amount of money on new technologies that simply are not cost-effective."

These are among the study's findings:

- Adding one hospital with a cardiac catheterization lab per million population is associated with an increase of 2.2 percent per beneficiary in the number of cardiac care hospitalizations that involve a catheterization procedure.
- Adding one hospital capable of performing percutaneous transluminal coronary angioplasty per million population is associated with an increase in spending of approximately $1.3 million per 100,000 cardiac beneficiaries per year.
- Adding one hospital per million population capable of handling implantable cardioverter defibrillators leads to an increase in spending of about $1.1 million per 100,000 cardiac care beneficiaries per year.

In a Webcast discussion of the report on the BCBSA Web site, Carolyn Clancy, M.D., director of the federal Agency for Healthcare Research and Quality, hailed the study.

"We know very little about the benefits and potentially the harms of some of these new technologies," she said. "This is particularly true in the diagnostic arena. All over America doctors are ordering X-rays and radiological procedures, and before the patient can have the test, you have to fill out why you are ordering it. But that isn't captured anywhere, so it's very hard to figure out what the benefit is of a particular procedure.

"We don't have to begin thinking about how to slow technology if we can create better evidence that is transparent and available to all stakeholders," she added. "Where we don't have evidence, we need to identify the resources to support practical clinical trials—that is, trials that actually [help answer the questions of whether it is] worth paying for and what is the expected benefit."

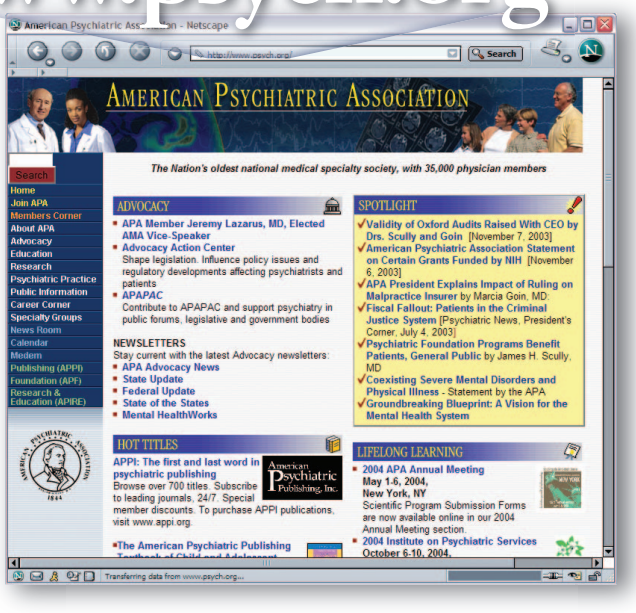
The Webcast is posted on the Web at <www.connectlive.com/events/bcbs-nov2003>. "The Relationship Between Technology Availability and Health Care Spending" is posted at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.537v1.pdf>. ■

Association News

Visit the New Face of APA

APA's new eye-catching, user-friendly Web site is now live and remains at the Web address of the old site, <www.psych.org>. The redesigned homepage will make it easier to learn about APA's advocacy initiatives and CME opportunities and the latest titles from American Psychiatric Publishing Inc. It will also be a quicker trip to the members-only section and to information on APA's research and psychiatric practice initiatives. Special notices about timely events—such as APA's 2004 election and next May's annual meeting—are also posted on the homepage.

To make the site as responsive as possible to members' needs on an ongoing basis, APA invites you to send your comments to webfeedback@psych.org. ■



Publishing During Residency: Yes, You Can Do It

BY SRIRAM RAMASWAMY, M.D.

As a third-year resident, I had the pleasure of being the coauthor of a publication and would like to encourage other residents to publish. Although lack of time and competing demands can be obstacles, accelerated learning, increased understanding of one's cases, and professional growth are among the satisfactions of undertaking the task of doing research and writing for publication as a resident.

My first report was about a case of somnambulism in a patient taking sodium divalproex and zolpidem. The patient reported episodes of sleepwalking while taking both medications but not either drug alone. The attending asked me to join him in writing a case report. I had minimal research experience and had not written a case report before. He encouraged me to try and assured me of his continued assistance. As it turned out, it was not difficult to produce the initial draft, as all I had to do was write a concise and coherent case summary.

A literature search on MEDLINE yielded references on drug-induced somnambulism. The challenge was making sure that I had thoroughly referenced the topic and located the articles. I also gained more insight into the clinical effects of the two drugs, including adverse reactions, and a better understanding of sleep architecture.

The most difficult part of writing the case report was the case-discussion section. Initially I was discouraged by this seemingly daunting task, and I found myself procrastinating. With the help of my attending, I finally dug in.

Dr. Ramaswamy is an associate chief resident (PGY-3) at the Creighton-Nebraska Psychiatry Residency Program in Omaha, Neb.

The process was laborious but also exciting. We had to provide as much objective evidence as we could for the adverse reaction while acknowledging the limitations of routine clinical care. The best evidence would have been a polysomnogram, but it was not indicated for a condition that could be cured by drug discontinuation alone. I learned about the Naranjo Adverse Drug Reaction Probability Scale, which is an objective measure of an adverse drug reaction. It resulted in a micro dissection of the case, bringing many clinical pearls my way. Ultimately we concluded that a probable interaction between zolpidem and sodium divalproex led to somnambulism.

In our efforts to have the manuscript conform to the journal requirements, I learned the art of weeding out extraneous material while retaining important case details. The sharp reviews by my co-authors and the journal editors further refined the manuscript.

Although the submission and review process took several months, the joy of having my first publication while a resident was worth the time and effort. I strongly feel that the guidance and support of mentors are critical for enhancing residents' professional growth. During the preparation of this case, my mentors helped me recognize potential confounding factors and cautioned me about jumping to conclusions.

The most common reason cited by residents for not doing research and writing is lack of time due to clinical responsibilities. Although I agree that residents' clinical workload can be tiring and time consuming, it is not impossible to do literature searches about unusual cases, which can positively influence case management.

Even if a research career is not a goal, residents who plan an academic career must be able to read critically, assess medical literature, and possess good writing skills. Participation in scholarly activity (publishing papers, presenting abstracts, submitting grant or protocol proposals, and so on) during residency can be a valuable experience that contributes to professional growth.

Case material is everywhere: you can encounter unusual cases either in your outpatient clinic or at 3 a.m. in the ER. Not only are novel cases of interest to other psychiatrists, but also they contribute to the growing science of psychiatry. It is ultimately we who have the duty to disseminate such valuable information.

Journals like *Psychiatric Services* and the *Jefferson Journal of Psychiatry* have sections dedicated to contributions by and for trainees or about training in psychiatry.

The experience of publishing has spurred me to write more papers. I have another case report accepted for publication and a couple more manuscripts in the submission process.

I would like to quote a remark by James T. Hardee, M.D., in the November 1997 *Observer*, published by the American College of Physicians: "Publishing is a slow birthing process. But once you get your first one done, it's sort of addictive." ■

Professional News

Barton Scholarship Seeks Applicants

BY CATHY TASMAN

People sometimes ask me, "Why does the APA Alliance need to award an educational scholarship to a physician's family? Aren't they wealthy? How could a son, daughter, spouse, or partner not be able to afford to go to college?"

My reply stems from personal experience with scholarship applicants, whom I usually interview by phone as part of the application procedure. There can be many personal traumatic situations in the life of a physician, sometimes hidden, sometimes unexpected, that can have a devastating impact not only on the physician, but also on the spouse and/or children.

For example, due to stigma and sometimes a sense of denial, a physician may successfully hide a drug or alcohol dependency from his or her partner, spouse, colleagues, or patients until the physician becomes so impaired that he or she must enter a diversion program through a physician's wellness program or a state-licensing board to continue practicing medicine. Sometimes a physician may not be allowed to practice medicine for quite a while or may lose his or her license.

Cathy Tasman is president-elect of the APA Alliance and chair of its Elsa Barton Scholarship.

When a situation like this occurs, there may be a drastic reduction in the income generated by the impaired physician, and the spouse may need to obtain additional education or take technical courses to support the family during this period. Likewise, a young adult family member of such a family may not have the funds to continue in a university program or to begin college.

While the Elsa Barton Educational Scholarship cannot address all the problems a family faces in the above situations, the scholarship can provide some financial assistance to a spouse or partner needing additional education to become the primary income provider. The scholarship can enable a daughter or son to remain at a university or to begin his or her college program or technical course of study.

APA members are asked to pass on information about the scholarship to those who may need it. In addition, the APA Alliance invites donations to the fund. Donations are tax deductible. Checks made out to the "APAA Elsa Barton Scholarship Fund" may be mailed to Angela Poblocki, Executive Director, APAA, P.O. Box 285, North Boston, N.Y. 14110.

Scholarship applications may be downloaded from the APA Alliance's Web site at <www.apaalliance.org/scholarships_contests.htm> or obtained by calling (703) 907-7304. Applications and additional information are also available from Poblocki by mail at the above address or by e-mail at ang3689@aol.com. ■

In Memoriam

APA honors the following members whose deaths were reported to APA from August 1 to October 31. All deceased APA members are remembered at APA's annual business meeting, held each year at APA's annual meeting.

Lillian F. Bennett, M.D.
San Francisco, Calif.

Nathan K. Bernstein, M.D.
New Hartford, N.Y.

Stanley Bernstein, M.D.
New York, N.Y.

Irma J. Bland, M.D.
New Orleans, La.

John Alden Bowman, M.D.
Kokomo, Ind.

Bruce Braverman, M.D.
New York, N.Y.

James J. Cadden, M.D.
Peoria, Ill.

Dana Charry, M.D.
Princeton, N.J.

Edwin B. Dakay, M.D.
Henderson, Nev.

Lanford H. De Generes, M.D.
Columbia, S.C.

Ellen S. Dickinson, M.D.
Buffalo, N.Y.

Sidney Z. Hulbert, M.D.
Palos Verdes Estates, Calif.

Paul S. Jarrett, M.D.
Miami, Fla.

Clarence M. Johnson, M.D.
St. Simons Island, Ga.

Cyril David Jones, M.D.
Troy, Mich.

Francis W. Kelly, M.D.
Fairport, N.Y.

Zigmond Meyer Lebensohn, M.D.
Washington, D.C.

John Peter Lesniak, M.D.
Lake Winola, Pa.

Joseph H. Lindsay, M.D.
Dallas, Tex.

Aldo W. Mell, M.D.
Greensboro, N.C.

Philip J. Moorad, M.D.
San Antonio, Tex.

Ruben Nazario Rodriguez, M.D.
Rio Piedras, P.R.

Gerald T. Niles, M.D.
New York, N.Y.

Charles E. Peck III, M.D.
Santa Rosa, Calif.

Lawrence C. Sack, M.D.
Bethesda, Md.

Myron Guy Sandifer Jr, M.D.
Lexington, Ky.

Henry Z. Shelton, M.D.
Englewood, N.J.

Joseph L. Sheridan, M.D.
Adamstown, Md.

William M. Shipman, M.D.
Del Mar, Calif.

Paul Norfleet Stewart, M.D.
Indianapolis, Ind.

Moises Sucholeiki, M.D.
Jacksonville, Fla.

Clara Torda, M.D., Ph.D.
Brookline, Mass.

Herbert M. Weiner, M.D.
Los Angeles, Calif.

Stanley S. Weiss, M.D.
Englewood, Colo.

FDA Likely to Approve Drug For Bipolar Depression

Combining olanzapine and fluoxetine creates synergy between the two drugs' efficacy, but not in their side-effect profiles.

BY JIM ROSACK

A pair of recent studies provides strong evidence for the clinical practice of combining the SSRI fluoxetine (Prozac) with the second-generation antipsychotic olanzapine (Zyprexa). The combination appears to create a robust synergy with regard to the two drugs' effectiveness without increasing adverse events.

An olanzapine-fluoxetine combination (OFC) in one pill, to be marketed by Eli Lilly and Co. as Symbyax (pronounced SIM-bee-ax), received an approvable letter earlier this year from the Food and Drug Administration (FDA) and is expected to receive final approval by mid-2004. Symbyax will be the first FDA-approved drug for the treatment of bipolar depression.

> "The one thing we were hoping to see but did not was less weight gain."

A study of OFC in patients with bipolar depression appeared in last month's *Archives of General Psychiatry*. A long-term study of the use of OFC in patients with major depressive disorder, and in particular treatment-resistant depression, appeared in last month's *Journal of Clinical Psychiatry*. Both clinical trials were funded by Lilly.

Response More Robust After Week 4

In the first study, Mauricio Tohen, M.D., Dr.P.H., an associate clinical professor of psychiatry at Harvard Medical School and the McLean Hospital and a clinical research fellow at Lilly, followed 833 patients with bipolar depression in an eight-week, double-blind, randomized, controlled trial. Patients received OFC, olanzapine as monotherapy, or placebo.

Patients receiving OFC or olanzapine alone showed statistically significant improvements in depressive symptoms compared with the placebo group—as early as by the end of the first week. By the midpoint of the study, at week 4, the OFC group was statistically more improved than those taking olanzapine alone. That superiority continued through the end of the study.

"This really suggests," Tohen told *Psychiatric News*, "that the onset of action very much seems to be connected to the effects of olanzapine. But then, by week 4, what's really interesting is that the combination treatment seems to have a more robust response. You see a decrease in scores on the [Montgomery-Asberg Depression Rating Scale (MADRS)] of nearly 20 points. That's really quite significant."

By the end of the study, 24.5 percent of patients on placebo had met remission criteria of a 50-percent reduction in symptoms (measured by the MADRS), 32.8 percent of the olanzapine group achieved remission, and 48.8 percent of the OFC group achieved remission.

The only other medication to show efficacy in published studies of bipolar depression is lamotrigine (Lamictal), which carries an FDA indication for the prevention of relapse to either mania or depression in patients with bipolar disorder. In comparison, lamotrigine is associated with response rates of 48 percent to 54 percent in published studies. Compared with the olanzapine-fluoxetine combination, lamotrigine's speed of onset is slower. To avoid serious side effects, Lamotrigine must be started at low doses and slowly titrated upward.

The speed of onset of the combination, as well as the robustness of the two medications used together, left researchers at Lilly (including Tohen) pleasantly surprised. Researchers were also pleased by the comparative side-effect profiles.

"The one thing we were hoping to see but did not was less weight gain," Tohen said. "But there were no additional side effects with the combination treatment, and for that matter there were more discontinuations [from the study] for [patients taking] the monotherapy than with OFC."

Sara Corya, M.D., Lilly's associate medical director for Symbyax and first author of the second study, agreed. She told *Psychiatric News* that Lilly researchers have looked into the synergistic effects. In animal studies, OFC causes a significantly larger increase in available serotonin, norepinephrine, and dopamine than does olanzapine or fluoxetine alone.

On the side-effect side, "it looks like you would expect it to," Corya said, "with some of the side effects of olanzapine and some from fluoxetine, but then some of them sort of cancel each other out."

OFC Effective for Major Depression

In her study, Corya followed 560 patients who met criteria for major depressive disorder for a total of 76 weeks in an open-label study.

OFC was again associated with rapid, robust improvement in depressive symptoms (measured by improvements in MADRS scores). Overall, 62 percent of patients achieved a 50 percent or greater reduction in symptoms (defined as a response), and 56 percent of those were able to maintain that reduction of symptoms long enough to achieve two consecutive MADRS scores less than or equal to 8. Only 15 percent of patients experienced a relapse.

In patients who were termed "treatment resistant"—having previously failed two different antidepressant therapies of adequate dose for an appropriate length of time—53 percent met response criteria, 44 percent met remission criteria, and 25 percent relapsed.

It is important to note that treatment resistance is not related to severity of symptoms, which is a common misconception, Corya told *Psychiatric News*. Treatment resistance implies that patients have not responded to adequate appropriate treatment; severity of symptoms is irrelevant. Thus, even someone with a mild depression could be treatment resistant.

Corya noted that Lilly has data on more than 2,000 patients who took OFC in clinical trials, and the side-effect profiles look fairly good. Most side effects noted in the trials tended to be transient, such as somnolence. Corya observed a slightly higher incidence of tremor in the OFC group in her study than had researchers in other clinical trials; however, the tremor was not significant, and in some patients tremor decreased with time.

Tohen noted higher incidences of postural changes in blood pressure and gastrointestinal upset in the group taking OFC than in patients taking either placebo or olanzapine as monotherapy. However, neither appeared to be clinically significant, said Tohen. He noted that no increase in falls was seen as a result of blood pressure changes.

Rapid Relief of Symptoms

Overall, Tohen and Corya agreed that OFC appears to offer rapid onset of relief for depressive symptoms, achieving a robust and prolonged response—whether patients have bipolar or unipolar depression.

For patients with bipolar disorder, however, OFC "is effective on symptoms of mania as well as symptoms of depression," Tohen noted, "and that really is a treatment that is optimum."

An abstract of "Efficacy of Olanzapine and Olanzapine-Fluoxetine Combination in the Treatment of Bipolar I Depression" is posted on the Web at <http://archpsyc.ama-assn.org/cgi/content/abstract/60/11/1079>. An abstract of "Long-Term Antidepressant Efficacy and Safety of Olanzapine/Fluoxetine Combination: A 76-Week Open-Label Study" is posted at <www.psychiatrist.com/abstracts/200311/110310.htm>. ■

Excess Bleeding After Surgery Found In Patients Taking SSRIs

What's good for the mind may not be so good for the body—at least, not when you are headed into the operating room.

BY JIM ROSACK

A large new European study strongly suggests that patients taking SSRIs are nearly four times more likely to require a blood transfusion following surgery than patients who are not taking a serotonergic antidepressant.

According to the new study, surgeons have not been in the practice of specifically noting whether patients are taking antidepressant medications prior to having a procedure. After analyzing data from the report, which appeared in the October 27 *Archives of Internal Medicine*, they may consider doing so.

A group of researchers at St. Elizabeth Hospital and TweeSteden Hospital, both in Tilburg, the Netherlands, along with investigators at the University of Utrecht's Institute for Pharmaceutical Sciences at Utrecht University, undertook a retrospective follow-up study of hospital and pharmacy data to look for relationships between the need for blood transfusion following orthopedic surgery and the use of serotonergic antidepressants.

A total of 520 patients were classified as users of serotonergic antidepressants (any serotonin reuptake inhibitor, or venlafaxine and clomipramine), users of nonserotonergic antidepressants, or nonusers of an antidepressant. Patients taking aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs), steroids, calcium channel blockers, and other medications commonly linked to bleeding problems were also identified.

In addition, the researchers tracked whether each patient had diabetes, heart failure, hypertension, hepatic or renal disorders, or bleeding disorders.

Of the 520 persons who underwent hip, knee, or spinal surgery from January 1, 1999, through December 31, 2000, 40 (8 percent) were taking antidepressants at the time of surgery. Of that group, 26 patients were taking a serotonergic antidepressant, and 14 were taking nonserotonergic antidepressants. Of those 26 patients, six required blood transfusions, while only one of the 14 patients taking nonserotonergic medications required a transfusion.

"Use of [serotonergic] antidepressants was significantly associated with increased blood loss during surgery (1,019 mL of blood lost for users, compared with 582 mL for nonusers)," the authors concluded. "The risk of blood transfusion almost quadrupled for the serotonergic antidepressant group, compared with the [antidepressant] nonusers."

The elevated risk for transfusion was not found for nonserotonergic antidepressants, calcium channel blockers, or steroid treatment. Users of both aspirin and NSAIDs in the study had expectedly elevated risks for transfusion.

The authors noted that there is some evidence that serotonin concentrations within blood platelets is reduced by SSRIs, leading to decreased platelet activation and more bleeding. This, they speculated, may be exacerbated by increased serotonin levels thought to be associated with surgical procedures. In essence, surgical patients experience the effect twice, once from their medication, then as a transient effect during surgery.

The authors noted that Dutch orthopedic surgeons are now learning to pay attention to their patients' medications more closely—looking and listening for the mention of any serotonergic antidepressant. They advise surgeons everywhere to follow that lead.

An abstract of the study, "Relationship of Serotonergic Antidepressants and Need for Blood Transfusion in Orthopedic Surgical Patients," is posted on the Web at <http://archinte.ama-assn.org/cgi/content/abstract/163/19/2354>. ■

Questionnaire Detects Rare Childhood Disorder

A new questionnaire designed to assess symptoms of selective mutism in children appears to be a reliable instrument.

BY CHRISTINE LEHMANN

Selective mutism (SM) is a rare disorder that often begins when children start preschool. Despite talking normally at home, many children with the condition fail to speak to teachers or other nonfamily members, a condition that interferes with their educational and social development.

"Nearly all children with SM perceive their home as a safe zone. When they leave home to attend school, they often become extremely anxious, clingy, and uncommunicative," according to Sucheta Connolly, M.D., director of the pediatric and anxiety disorders clinic at the psychiatry department at the University of Illinois at Chicago.

The prevailing view among clinicians is that SM is caused by social anxiety rather than willful defiance of parents or teachers, although oppositional behavior may be a secondary effect. Most clinicians consider SM as an anxiety spectrum disorder because it can last from a few months to years depending on the severity of anxiety and avoidance symptoms.

In addition, about 20 percent of children with SM have some type of speech and language problem, which may exacerbate their social anxiety, according to Connolly.

Studies in the last few decades have confirmed a strong link between SM and anxiety disorders—in particular, social phobia. The term "elective mutism" used in *DSM-III* was changed to "selective mutism" in *DSM-IV*.

However, evidence-based research into the diagnosis and treatment of SM has been lacking, according to Lindsey Bergman, Ph.D., associate director of the childhood OCD, anxiety, and Tourette's disorder program at the University of California at Los Angeles.

Bergman developed the Selective Mutism Questionnaire (SMQ), which she described in an interview with *Psychiatric News*. "The SMQ focuses on three settings where children spend their time—school, family/home, and public/social settings. There are 17 items assessing speaking, and parents and teachers are asked to assess the level of interference in functioning caused by their child's not speaking in each setting," said Bergman.

A pilot test of the questionnaire involved a clinical sample of about 45 children aged 4 to 10 who met *DSM-IV* criteria for SM. The SMQ confirmed their diagnosis and indicated that 95 percent also met the diagnostic criteria for social phobia. SM was more common in girls, who accounted for 69 percent of the diagnosed subjects. Children with SM spoke most often to family members, relatives, and friends outside school; they spoke less often with friends at school, physicians or dentists, and teachers or school staff, said Bergman. "These results are consistent with findings from the literature about SM."

She recently tested the SMQ in a much larger sample involving 595 parents who thought their children had SM. They were recruited from Internet sites concerned with that disorder or anxiety disorders, said Bergman. "I was surprised by how similar the results were to the pilot clinical sample. Subjects in both of the samples spoke rarely in school and public/social settings compared with family/home settings."

When Bergman compared the SM samples identified in her pilot tests with a small clinical sample of children diagnosed with anxiety disorders including social phobia and separation anxiety disorder, it was clear that the children with SM spoke less often in all three settings. "That indicated that the SMQ could discriminate children with SM from children with other anxiety disorders," said Bergman.

To distinguish SM from communication and other anxiety-spectrum disorders, Bergman recommended using the following assessment tools that can help in diagnosing SM and its severity:

- The Anxiety Disorder Interview Schedule for Children (ADIS-C) with supplemental questions about social phobia
- The Social Anxiety Scale for Children–R (SASC-R)
- The Vineland Language Scale from the Vineland Adaptive Behavior Scale for parents and teachers
- The Achenbach scales (parents and teacher)

Clinicians should require parents to videotape the child's speaking at home so clinicians can confirm verbal reports.

"The SMQ is also an important tool for measuring the effectiveness of clinical treatment in children. Our clinical experience is that SSRIs approved for anxiety disorders can be useful in cases of severe SM, as can modified cognitive-behavioral therapy," Connolly told *Psychiatric News*.

Information about the SMQ can be obtained from Bergman by e-mail at llbergman@ucla.edu. ■

Treatment Success Hinges on Unique Alliance of Psychiatrists, Patients

The therapeutic relationship between psychiatrist and patient is special in medicine and if carefully built should lead to an alliance that increases the chances that treatment will achieve its goals.

BY MARK MORAN

The physician's alliance with the patient is "the best-kept secret of medical care" and a special feature of the practice of psychiatry that sets it apart from all other specialties.

So said Leston Havens, M.D., and Harold Eist, M.D., in separate lectures at APA's 2003 Institute on Psychiatric Services in Boston.

The two speakers, well known to APA audiences, reminded clinicians of the centrality of the relationship between patient and doctor—the "fit" between healer and health seeker—in the outcome of any therapeutic encounter.

Havens said there has been a growing scientific recognition of the importance of the therapeutic relationship to patient outcome, reflected in a burgeoning body of literature on the subject in the last 25 years.

It is now the "most robust finding in all of therapeutics," he said.

Both speakers said that the alliance between doctor and patient was dependent on the recognition of the "personhood" of the patient—a concept that is at variance with the authoritarian nature of the medical encounter as it is traditionally understood.

"What we ally with is another person," said Havens, a professor of psychiatry at Harvard Medical School. "But personhood is something that we approach—if we approach it all—with only a vague sense of what it might mean."

Eist focused on the psychodynamics of medication, emphasizing the importance of the relationship between the prescribing physician and the patient in successful medication use.

He noted the exponential growth in literature on the subject of compliance with medication regimens: between 1981 and 1995, there were 2,500 articles on medication compliance, compared with just 500 studies up until 1975, he said.

He also cited a 1992 meta-analysis revealing that noncompliance was responsible for 6 percent of all hospitalizations and was "the single most correctable excess cost factor in medicine."

But Eist also expressed disdain for the term "compliance," a concept that he said has harmed medical care with its implications of passivity on the part of the patient.

Instead, he said, what is necessary for the successful use of medication is cooperation.

"Cooperation includes the patient as an active partner in a shared process, thereby enhancing self-esteem, which in turn facilitates more effective learning and more effective medication titration, lower overall dosages, and fewer side effects," Eist said.

Eist is a private practitioner in Bethesda, Md., and a former APA president.

In a series of vignettes from his own practice, he described the subtleties involved in the psychodynamics of medication, explaining how a more simplistic approach in each case might have resulted in a breakdown in cooperation and in treatment failure.

"Careful listening requires an attention to concrete, symbolic, metaphorical, direct, hidden, confused, and affective components of the patient's communications," he said. "Unless we combine this kind of dynamic listening with our pharmacological knowledge, our medication practice will remain arbitrary, crude, superficially symptom focused, and often wrong."

With 75 percent of all psychiatric patients on medication, Eist said, "it is clearly urgent that we learn how to develop effective treatment relationships that involve much more than writing prescriptions." ■

Impulsiveness, Aggression Underlie Many Adolescent Suicides

Impulsiveness and aggression appear to be significant factors in many teenagers who attempt suicide.

BY JOAN AREHART-TREICHEL

Why do certain youngsters try to kill themselves?

Because of depression and hopelessness in some cases, and because of depression and hopelessness topped by impulsiveness and aggression in others, a new study suggests.

The study was conducted by Netta Horesh, Ph.D., of Bar-Ilan University, Alan Apter, M.D., of Tel Aviv University, and colleagues. Results appeared in the September *Journal of Nervous and Mental Disease*.

The investigators recruited 65 adolescents for their study—32 with major depressive disorder, 16 of whom had made a suicide attempt—and 33 with borderline personality disorder, 17 of whom had made such an attempt.

The researchers then assessed all of the subjects with instruments such as the Beck Depression Inventory, the Multidimensional Anger Inventory, and the Impulsiveness-Control Scale to determine whether they could gain insights into why some of the subjects had tried to kill themselves and others had not.

Depression and hopelessness were linked positively and significantly with suicidal behavior both in the major depressive subjects and in the borderline personality disorder subjects, the researchers found. What's more, impulsiveness and aggression were found to correlate significantly with suicidal behavior in borderline subjects. However, this was not the case for the subjects with major depression. Anger did not appear to play a role in suicidal behavior in either group.

An abstract of the study, "Comparison of the Suicidal Behavior of Adolescent Inpatients With Borderline Personality Disorder and Major Depression," is posted on the Web at <http://ipsapp002.1wwonline.com/content/getfile/4109/28/5abstract.htm>. ■

Mental Illnesses Linked To Lack of Brain Protein

The notion that swaggering mice might be connected with four mental illnesses in humans sounds far fetched. Yet more and more research points to a connection—through a gene called "reelin."

BY JOAN AREHART-TREICHEL

Back in 1951 a certain strain of lab mouse was discovered that acted, well, drunk. Even if these little "reeler" mice, as they were dubbed, had had human intelligence, they could not have foreseen what a splash they would make in the psychiatric research world half a century later.

The gene (or rather absence of gene) responsible for the mice's reeling was identified in 1995. Then the protein made by this gene was identified. And now the reelin protein seems to be present in abnormally low amounts in the brains of persons who have autism, bipolar disorder, major depression, or schizophrenia.

For example, S. Hossein Fatemi, M.D., an associate professor of psychiatry, cell biology, and anatomy at the University of Minnesota, and coworkers have found 43 percent less reelin protein in the cerebella of deceased autism patients than in the cerebella of deceased, psychologically healthy individuals. They have also discovered that individuals with bipolar disorder, major depression, or schizophrenia have less reelin protein in their hippocampi than do individuals who are psychologically healthy. John Davis, M.D., a psychiatric scientist with the University of Illinois at Chicago, and colleagues have found a 30 percent to 50 percent reduction of the reelin protein in the brains of deceased bipolar and schizophrenia patients compared with the amount in the brains of deceased, psychologically healthy individuals. What's more, two researchers at Oxford University in England—Sharon Eastwood, Ph.D., and Paul Harrison, M.D., Ph.D.—have essentially replicated Davis and team's schizophrenia-reelin findings. They published their results in the September *Molecular Psychiatry*.

Implications Far Reaching

Such findings, of course, raise some provocative questions.

First, if a person inherited a particular version of the reelin gene that led to insufficient production of the reelin protein in the brain, could that reelin insufficiency help set the stage for autism, bipolar disorder, depression, or schizophrenia? Very likely, some evidence suggests. For instance, two scientists working at the University Campus Bio-Medico in Rome—Flavio Keller, M.D., chief of the Laboratory of Developmental Neuroscience and Neural Plasticity, and Antonio Persico, M.D., chief of the Laboratory of Molecular Psychiatry and Neurogenetics—studied children with autism, as well as their parents, to see whether they might be able to find a link between the possession of a particular gene variant and autism susceptibility. They discovered a link between autism vulnerability and possession of a particular version of the reelin gene. This finding also indicated that the reelin gene in humans is located on chromosome 7.

Second, if a person inherited a particular variant of the reelin gene that in turn led to inadequate manufacture of the reelin protein in the brain, how might this inadequate production help lay the foundation for autism, bipolar disorder, depression, or schizophrenia?

One possible answer may have been found by Gabriella D'Arcangelo, Ph.D., the principal discoverer of the reelin gene. Back in 1995 D'Arcangelo was a post-doctoral scientist with Tom Curran at the Institute of Molecular Biology in Nutley, N.J. About the time that she and her colleagues identified the reelin gene, they also discovered that the reelin protein is made in the brain during the earliest phases of brain development and that it serves as a stop sign for newborn neurons so that they end up in their proper places in the brain. Thus, it is quite conceivable that if a particular version of the reelin gene were inherited that led to insufficient reelin protein production in the brain, that sparse production in turn might allow newly developed neurons to end up in the wrong places in the brain. The resulting neuronal disarray, then, might allow for the development of autism, bipolar disorder, depression, or schizophrenia.

Gabriella D'Arcangelo, Ph.D., is the principal discoverer of the reelin gene.

Therapeutic Scenarios Anticipated

Finally, might all of these discoveries coupling the reelin gene and the reelin protein with autism, bipolar disorder, depression, and schizophrenia be used to help persons with those mental illnesses? Certainly not immediately, but perhaps eventually.

For example, as Keller told *Psychiatric News*, "It appears that down-regulation of reelin leads to alterations in dopaminergic and GABAergic signaling pathways. There

please see ***Protein*** *on page 17*

Interventions Reduce Risk Of Schizophrenia Relapse

Involvement of patients and families in recognizing early warning signs of schizophrenia relapse and assertive outreach by an outpatient treatment team can prevent relapse and avoid rehospitalization.

BY MARK MORAN

Early intervention at the first sign of prodromal symptoms can prevent full relapse in people with schizophrenia, said Marvin Herz, M.D., in a lecture at APA's 2003 Institute on Psychiatric Services in Boston in October.

Herz was the 2003 recipient of the American Psychiatric Foundation's Alexander Gralnick, M.D., Award for Research in Schizophrenia, and his lecture was presented in connection with the award.

While the costs of outpatient intervention during the prodromal phase are not insignificant, the strategy has been shown to be cost-effective when considering overall costs—especially the costs of rehospitalization, which are avoided through prevention.

Herz, whose groundbreaking research on prodromal symptoms of relapse has informed APA's treatment guideline for schizophrenia, provided an overview of prevention research in the last 20 years and outlined the problems and possibilities of early intervention.

The strategies he described entail the involvement of the family and the patient in recognizing early warning signs of relapse and an assertive outreach approach by the outpatient treatment team. He added that British psychiatrists and researchers have found success using cognitive-behavioral therapy to reduce the disabling effects of delusional thinking that may appear in the prodromal phase.

"We advocate continuing and ongoing collaboration with the family," said Herz, a professor of psychiatry at the University of Miami School of Medicine and chair of APA's work group that developed a practice guideline on the treatment of schizophrenia.

"We think these early-intervention strategies should be routine practice in outpatient services. And we need more research to refine and improve techniques of recognizing early warning signs and [to refine and improve] treatment strategies.

"Through these, we can reduce pain and suffering of patients and family members and maybe improve long-term outcome by reducing relapse. We need to find methods of improving coping skills [of families and patients]. With increased coping skills, you can help them deal more effectively with stress and recognize prodromal symptoms."

Primary Prevention Elusive Goal

The notion of prevention—especially primary prevention—of a costly, extraordinarily disabling disease for which there is no cure is a tantalizing one.

As early as 1980, Herz and colleagues performed retrospective and prospective studies of patients with schizophrenia to determine the kinds of symptoms they experienced immediately prior to the onset of disease.

Symptoms that were identified include trouble sleeping and concentrating, depression, a feeling of being overwhelmed, tension, nervousness, and worry about impending doom.

Marvin Herz, M.D.: "We think these early-intervention strategies should be routine practice in outpatient services."

Also prominent during the prodromal phase was the appearance of idiosyncratic behaviors: one patient might begin to pace obsessively while alone in his room; another patient might dress bizarrely.

Prevention of schizophrenia, however, is difficult for many reasons. Primary among these is that prodromal symptoms are not specific to schizophrenia. Many individuals who experience such symptoms may never go on to develop the disease, and the problem of false-positives plagues prevention efforts at both the primary and secondary levels.

Ethical issues surround efforts at primary prevention. "We don't have the ability to say [that] this person will definitely develop schizophrenia," Herz said. "It can lead to stigma, demoralizing individuals who may never get the disorder."

Nonetheless, Herz cited research out of Australia aimed at identifying people at risk for first-episode schizophrenia in a community sample of 1,000 young people. The study appeared in the December 2002 *American Journal of Medical Genetics*.

Sixteen individuals were identified on the basis of prodromal symptoms and given stress-management training and low-dose antipsychotics. The researchers found the incidence of schizophrenia in the community sample was significantly lower after the intervention than before.

Herz said the study was not controlled and was limited by the problem of false-positives. Still, he called the research promising, laying the groundwork for future primary-prevention efforts.

Secondary Prevention Promising

Herz's recent work has focused on the use of secondary prevention strategies to avoid relapse in patients who have been hospitalized and treated for the disease previously.

He said the relationship between prodromal symptoms and true relapse is not a simple, mechanistic one, but a complex, dynamic one involving stressful life events, the patient's coping skills and personality traits, and the support and coping skills of the family.

"Good treatment doesn't have to cost more. It can cost less."

In a study by Herz and colleagues published in the March 2000 *Archives of General Psychiatry*, 82 outpatients with schizophrenia or schizoaffective disorder diagnosed with *DSM-III-R* criteria were randomly assigned to receive either a program for prevention of relapse (experimental group, 41 subjects) or treatment as usual (control group, 41 subjects). Patients in both groups were prescribed standard doses of maintenance antipsychotic medication.

The program for prevention of relapse consisted of a combination of psychoeducation, active monitoring for prodromal symptoms with clinical intervention when such symptoms occurred, weekly group therapy for patients, and multifamily groups. The treatment-as-usual group received biweekly individual supportive therapy and medication management.

After 18 months, 17 percent of the patients in the experimental group had experienced relapse, compared with 34 percent in the control group. Twenty-two percent of the experimental group had to be rehospitalized, compared with 39 percent in the treatment-as-usual group.

During his lecture at the institute, Herz said the ambulatory care costs in the experimental group were higher—as expected—but the overall costs were lower than those of the treatment-as-usual group.

"Good treatment doesn't have to cost more," he said. "It can cost less."

An abstract of "Prediction and Prevention of Transition to Psychosis in Young People at Incipient Risk for Schizophrenia" is posted on the Web at <www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12457389&dopt>. An abstract of "A Program for Relapse Prevention in Schizophrenia" is posted at <http://archpsyc.ama-assn.org/cgi/content/abstract/57/3/277>. ■

NARSAD Honors Groundbreaking Psychiatric Researchers

Research discoveries that have helped change the face of psychiatric treatment win six scientists NARSAD awards.

BY JOAN AREHART-TREICHEL

Each year at its Gala Awards Dinner, the National Alliance for Research on Schizophrenia and Depression (NARSAD) awards a handful of psychiatric scientists who have made outstanding lifetime achievements relevant to schizophrenia and the depressions.

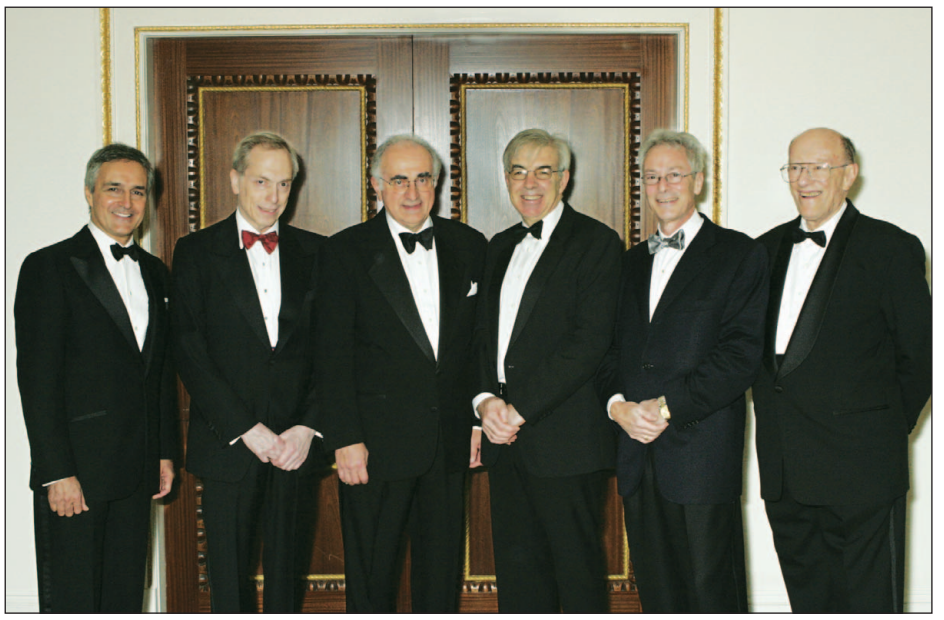
The researchers awarded at this year's Annual Gala Awards Dinner, which was held in New York City on October 17, were Ross Baldessarini, M.D., of Harvard University; Leon Eisenberg, M.D., of Harvard University; Robert M.A. Hirschfeld, M.D., of the University of Texas Medical Branch in Galveston; Robin Murray, M.D., D.Sc., of the Institute of Psychiatry in London, England; Solomon Snyder, M.D., of Johns Hopkins University; and Leonardo Tondo, M.D., of Harvard University.

Baldessarini, Hirschfeld, and Tondo received the Nola Maddox Falcone Prize for Affective Disorders Research. Baldessarini and Tondo have provided unique insights into bipolar illness and the ability of lithium to improve and prevent manic-depressive episodes and to decrease suicidality. Hirschfeld is an innovative leader in the early identification and treatment of bipolar illness.

Eisenberg received the Ruane Prize for Child and Adolescent Psychiatry Research. He has been a leader in child psychiatry for more than 40 years through his work in pharmacological trials, research, teaching, and social policy and for his theories of autism and social medicine.

Murray received the Lieber Prize for Schizophrenia Research for providing fundamental insights into the importance of early brain development in schizophrenia. He has also made landmark contributions to understanding schizophrenia risk factors.

Snyder was awarded the Dr. Patricia S. Goldman-Rakic Memorial Prize for Cognitive Neuroscience. During the 1960s and 1970s, Snyder and his team identified the brain's dopamine and opiate receptors and then went on to define the role of several endorphins as neurotransmitters. ■



Six scientists were awarded at this year's NARSAD Gala Awards Dinner (from left): Leonardo Tondo, M.D., Solomon Snyder, M.D., Ross Baldessarini, M.D., Robin Murray, M.D., D.Sc., Robert Hirschfeld, M.D., and Leon Eisenberg, M.D.

Child's Cortisol Level May Signal Depression Risk

Could a hormone test for cortisol given during childhood reveal whether a person will be at risk for depression as an adult? The answer seems to be a definite maybe.

BY JOAN AREHART-TREICHEL

Persons who secrete an excessive amount of the stress hormone cortisol in the presence of stressful situations may have a higher risk of developing depression, since stress has been closely linked with the onset of depression, and adults with major depression can have elevated cortisol levels. But could a particular cortisol-secretion profile during childhood be a biological marker for depression vulnerability? Quite possibly, preliminary research data suggest.

The findings come from Adriana Feder, M.D., an assistant clinical professor of psychiatry in medicine at Columbia University, and colleagues. Feder discussed them at the 15th Annual Scientific Symposium of the National Alliance for Research on Schizophrenia and Depression (NARSAD) in New York City in October. NARSAD uses its scientific symposia to showcase some of the more exciting research being pursued by young NARSAD-sponsored investigators.

Adriana Feder, M.D.: Mentally healthy children likely to develop major depression as adults have cortisol profiles virtually identical to those of youngsters who are already depressed in childhood.

During the 1970s, the 24-hour cortisol-secretion patterns of 50 depressed, 24 anxious, and 12 psychologically healthy children were assessed. These 86 youngsters were then followed up 10 to 15 years later to learn their psychological status.

It turned out that 20 who had been either psychologically healthy or anxious, but not depressed, as youngsters went on to develop a major depression as an adult.

Feder and her colleagues used these subjects and the data about them to conduct their own study to see whether a person's cortisol-secretion pattern during childhood might reflect depression vulnerability.

In one phase of their study, the researchers examined the cortisol-secretion patterns of the 50 subjects who had been depressed as youngsters. They found that the patterns were similar—an abnormally elevated cortisol level during the evening and an abnormal delay in the rise of cortisol during the night. This finding suggested that this deviant childhood cortisol-secretion profile might be a biological marker for depression susceptibility during childhood.

In another phase of their study, Feder and her team scrutinized the childhood cortisol-secretion patterns of the 20 subjects who had not been depressed as youngsters, yet who developed a major depression as adults. They found that the patterns were essentially identical to the atypical childhood cortisol-secretion profile exhibited by the 50 subjects who had been depressed as youngsters.

This finding implied that this abnormal childhood cortisol-secretion profile might be a biological marker not just for depression susceptibility during childhood, but also for depression susceptibility during adulthood.

Putting both findings together, the researchers raised the provocative possibility of identifying, via childhood cortisol-secretion tests, individuals who are at risk of depression either during childhood or adulthood.

This conclusion was voiced at the NARSAD symposium by Husseini Manji, M.D., chief of the Laboratory of Molecular Pathophysiology at the National Institute of Mental Health. (Manji was asked to comment on the research of Feder and her team, as well as on other studies presented at the symposium.)

But even if individuals who were especially vulnerable to depression because of an abnormal cortisol response *were* identified, what could be done to keep them from developing depression? Using cognitive-behavioral therapy to teach them how to better deal with stress is one possibility, Feder said. Also, drugs are being developed to counter excessive cortisol secretion, and such drugs might likewise benefit individuals with this risk factor, she added. ■

Researchers Try to Explain Link Between Depression, Brain Chemical

Brain-derived neurotrophic factor has an antidepressive effect and may well exert it via the hippocampus. However, it also seems to have a "prodepressive" effect mediated by two pleasure centers in the brain.

BY JOAN AREHART-TREICHEL

Increasing—and intriguing—links are being made between a brain growth factor called brain-derived neurotrophic factor (BDNF) and depression.

For instance, it looks as though abnormally low levels of BDNF may be implicated in depression, since depressed persons have been found to have abnormally low levels of BDNF in their blood, and since depressed persons receiving antidepressants have been found to have higher BDNF levels in their blood.

But how might abnormally low levels of BDNF trigger depression? Perhaps by not being present in large enough quantities in the hippocampus region of the brain, because when rats are given antidepressants, it increases BDNF levels in the hippocampus.

Nonetheless, the answer is probably more complicated, because a new rodent study suggests that when BDNF is injected into some other areas of the brain, it exerts a depression-causing rather than depression-reducing effect.

The study was conducted by Amelia Eisch, Ph.D., an assistant professor of psychiatry at the University of Texas Southwestern Medical Center at Dallas, and coworkers.

Rats, of course, cannot tell anyone when they are depressed, but a number of scientists, including Eisch, believe that a so-called forced-swim test can be used as an indirect gauge of depression-like behaviors in rats. Rats do not like water, so when they are placed in water, they are usually eager to swim and get out of it. If the rats do not swim eagerly to get out, the researchers conclude that they have the equivalent of depression.

Eisch and her group knew that when BDNF is injected into the hippocampus of rats, they do even better on the forced-swim test than control rats do, implying that a surplus of BDNF in the hippocampus can exert an antidepressant effect. So they wondered what effect BDNF would have on several brain areas involved in pleasure.

They injected BDNF into an area of the rats' brains known to be involved in pleasure—the ventral tegmental area—then had the rats engage in the forced-swim test. The first day afterward, the rats swam just as well as control rats, showing that they had learned the technique with no difficulty. On the second day, however, they did not swim as well as the control rats, suggesting that they were depressed.

Thus, it looks as if BDNF may have exerted a depressive effect in the rats' ventral tegmental area. Eisch and her colleagues were surprised at this finding. They had expected BDNF to have an antidepressive effect on the ventral tegmental area, just as it has on the hippocampus.

Eisch and her team then decided to see whether the depressive effect that BNDF was exerting on the ventral tegmental area was also being passed on to a neighboring pleasure center, the nucleus accumbens, since the ventral tegmental area was already known to send BDNF to this brain structure.

To test this hypothesis, they injected a protein that blocks BDNF's action into the nucleus accumbens of rats. The rats were put through the forced-swim test. On the first day, they swam the same as the control rats. On the second day, they swam even better than the control rats. Eisch and coworkers used other tests to find that anxiety and locomotion were not altered in the animals.

This finding thus suggested that, indeed, BDNF made in the ventral tegmental area and then sent to the nucleus accumbens had a depressive effect.

So it looks as though BDNF may exert an antidepressive effect on the hippocampus, but a depressive effect on the ventral tegmental area and nucleus accumbens, Eisch and her team concluded. The results also suggest that while the hippocampus is critical in depression, the pleasure pathways of the brain may play a role as well.

Eisch reported these findings in October at the 15th Annual Scientific Symposium of the National Alliance for Research on Schizophrenia and Depression, which funded the research with a two-year Young Investigator Award. The results are also in press with *Biological Psychiatry*. ■

Protein

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may also be an important link between reelin and cholinergic neurotransmission. These findings are interesting because all these neurotransmitter systems have been implicated in autism (and other psychiatric disorders of neurodevelopmental origin) and can be targeted by existing (or still to be developed) drugs. . . .[Also] if a decrease in reelin expression/function is indeed a risk factor for autism or other neurodevelopmental conditions, one would think that increasing reelin levels and/or function may ameliorate the disease. Theoretically, this could be obtained either by selectively turning on reelin gene expression (which is technically very difficult) or perhaps more simply by increasing reelin protein levels. . . ."

Recently, D'Arcangelo (who is now an assistant professor of neurology and pediatrics at Baylor College of Medicine) and her colleagues have found dramatic impairment in the growth of branches of nerves in the brains of mice lacking the reelin gene. They discovered that, by adding the reelin protein to cultures of brain cells obtained from these mice, the defects could be repaired to a large extent.

"So these are exciting new findings," D'Arcangelo declared at a recent symposium sponsored by the National Alliance for Research on Schizophrenia and Depression in New York City.

In other words, in addition to serving as a stop signal for neurons during early brain development, Reelin appears to be a remodeling factor for nerve-branch development. "So it is conceivable that at some point in the future," D'Arcangelo told *Psychiatric News*, "the reelin protein, or parts thereof, might be injected into the brains of persons with autism, bipolar disorder, depression, or schizophrenia. The injections might lead to [nerve-branch] growth in their brains since [nerve-branch growth] occurs throughout life, and [such injections] might help correct their mental illnesses."

One day it may even be possible to diagnose a reelin deficiency in people at birth or even before and inject them with a drug that would switch on reelin production, Davis suggested. That switched-on production might correct faulty neuronal migration and the beginning of disorders like autism or schizophrenia.

In fact, the long-term psychiatric therapeutic potential of the reelin gene and of the reelin protein may be far more astonishing than even the most imaginative reelin scientist today can conceive. After all, as Fatemi told *Psychiatric News*, "Reelin can be found not just in many places in the brain and body, but in virtually all embryonic tissues, including those for teeth." ■

Dual Addictions Dominate Substance Abuse Treatment

Almost half of the more than 1 million Americans in treatment for addiction last year had a problem with both drugs and alcohol, according to findings from the National Survey of Substance Abuse Treatment Services.

BY EVE BENDER

About 1.1 million Americans received treatment for addiction to drugs, alcohol, or both on a typical day last year, according to findings from the 2002 National Survey of Substance Abuse Treatment Services (N-SSATS). Half of those receiving treatment were addicted to both drugs and alcohol.

A minority, 21 percent, were in treatment for alcohol abuse alone, and 31 percent were in treatment for drug abuse alone.

The largest proportion of those in treatment—48 percent—were being treated for addiction to drugs and alcohol. About 8 percent of the 1.13 million addiction patients were under age 18 last year.

Researchers with the Substance Abuse and Mental Health Services Administration (SAMHSA) conduct the survey annually to collect data on the characteristics of alcohol and drug treatment facilities across the United States. The survey results assist SAMHSA and state and local governments in evaluating the extent to which drug and alcohol treatment services are provided and forecasting the need for additional resources. SAMHSA also uses the results to update its databases containing information about treatment facilities in the United States.

A total of 13,720 treatment facilities, 96 percent of all eligible facilities, participated in the survey. Those not eligible included jails and prisons offering treatment services and facilities that did not collect data on treatment services.

The following are some of the characteristics of the treatment facilities for which data were available:

- Overall, 60 percent of facilities considered treatment for substance abuse problems (including alcohol abuse) their main focus, and a little more than 25 percent of the facilities considered both substance abuse and other mental health treatment services to be their focus. Approximately 8 percent of treatment facilities reported that providing mental health services was a primary aim, while 3 percent focused primarily on general health care.
- Seventy-four percent of facilities offered standard outpatient services, and 44 percent offered intensive outpatient services. A quarter of the facilities offered residential services, but just 4 percent of them offered treatment through inpatient services.
- Nearly half of the surveyed facilities offered treatment for people with mental illness and a substance use disorder.
- Thirty-seven percent of facilities offered programs or groups for adolescents, and 14 percent offered specialized services for people aged 65 and older.
- Of the 13,720 treatment facilities, 1,080 dispensed methadone or levo-alpha acetyl methadol as part of an opioid-treatment program.

In an October press release, SAMHSA Administrator Charles Curie said, "At SAMHSA, building treatment capacity is a high priority. We are hopeful that the president's Access to Recovery program will be funded to allow an additional 100,000 people to enter treatment and rebuild their lives."

In his January state of the union address, President Bush announced a three-year, $600 million federal treatment initiative, which would provide approximately $200 million in vouchers each year to support treatment for people with drug and alcohol problems.

As part of the initiative, state governors would compete for the funds, according to SAMHSA officials, which would be used to supplement existing treatment programs.

At press time, Congress had not yet approved a dollar amount for Fiscal 2004 appropriations to the Department of Health and Human Services, which is where funds for the Access to Recovery will be included.

Additional findings from the National Survey of Substance Abuse Treatment Services are posted on the Web at <www.samhsa.gov/oas/dasis.htm#nssats2 >. More information about Access to Recovery is posted at <www.whitehouse.gov>. ■

government news

McDermott

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fiscal and access problems of the health care system.

"Our ability to deal with access problems is limited because there is no real health care system," he said.

As in the 1990s, health care reform has become an important political issue. According to an analysis in the September 30 *New York Times*, "[As] the plight of the uninsured becomes more of a middle-class issue, . . . it is more politically potent."

According to a September Gallup poll, 43 percent of Americans cited a candidate's position on health care as "extremely important," ranking just below terrorism and the economy.

With the failure of managed care to reform the health care system, there appears to be increasing receptivity to proposals for a single-payer system of financing care.

An ABC News-*Washington Post* poll released in late October found that by a margin of 62 percent to 32 percent the public favors a "universal health insurance program, in which everyone is covered under a program like Medicare that's run by the government and financed by the taxpayers," as opposed to the "current health insurance system, in which people get their health insurance from private employers, but some people have no insurance."

That change is welcome news to McDermott, who introduced the American Health Security Act (HR 1200) last March. The bill, which has 40 cosponsors, would establish a national and universal health program that would be funded by the federal government and administered by the states *(Psychiatric News*, October 3).

McDermott looked back to the 1960s when asked to consider the bill's chances of passage. He said proposals for what would become the Medicare program had been "kicked around for a long time," but had been defeated by forces that included strong opposition from the AMA and health insurance carriers.

But ultimately, in 1965, McDermott said, pressure on politicians from constituents became too great to resist, and the legislation was passed.

McDermott voted against the Medicare legislation that passed the House of Representatives on November 22, charging that its "real goal" is to privatize Medicare (see page 2).

He added, "The bill is designed to protect and increase drug companies' and insurance companies' profits. The pharmaceutical industry will reap about $140 billion in profits if this becomes law. The bill explicitly prohibits the secretary of Health and Human Services from negotiating lower drug prices on behalf of America's 40 million Medicare beneficiaries."

McDermott cited stigma and ignorance as factors that have prevented passage of federal legislation promoting parity in benefits for mental illness with those for other forms of illness.

"The idea that one must pull oneself up by the bootstraps still has a lot of power," he said. Unless people have had direct contact with mental illness, they often do not understand that it is a chronic, but treatable disease.

"Get to know your local politicians. Become active in the community in visible ways," McDermott urged APA members. "Education about mental illness must be a constant process."

He praised the work of APA in helping to establish the Mental Health Caucus in the House of Representatives, which has worked to provide that education. ■

Women Migraine Sufferers More Prone to Panic Attack

Women who reported a history of migraine with aura were more than six times as likely to experience a full-blown panic attack, according to the results of a large-scale study on panic in older women.

BY EVE BENDER

Almost 10 percent of a sample of 3,369 postmenopausal women reported experiencing a full-blown panic attack in a six-month period prior to a Women's Health Initiative study. Women with migraines, emphysema, and depressive symptoms were more likely to experience panic attacks than those without these conditions.

As part of the study, which was published in the September 22 *Archives of Internal Medicine*, Jordan Smoller, M.D., Sc.D., and colleagues interviewed 3,369 women aged 50 to 79 between December 1997 and November 2000. The women were enrolled in the Women's Health Initiative, a multisite study designed to identify health problems in postmenopausal women. In addition to being the principal investigator on the study, Smoller is an assistant professor of psychiatry at Harvard Medical School.

Participants completed questionnaires pertaining to panic attacks, migraines, depression, and adverse life events such as the death or serious illness of a family member or friend.

Researchers distinguished between two types of panic episodes based on responses to the question about panic. They defined "full-blown panic" as an attack of sudden fear, anxiety, or extreme discomfort during the past six months accompanied by four or more symptoms from a 12-symptom checklist. In "limited-symptom panic," the episode is accompanied by fewer than four symptoms on the checklist.

Smoller found that 17.9 percent of the women experienced one of the two types of panic in the six months prior to being interviewed—9.8 experienced full-blown panic, and 8.1 percent experienced limited-symptom panic attacks.

"This finding was somewhat surprising," Smoller told *Psychiatric News*. "Previous studies have suggested that panic attacks might be relatively uncommon in older women."

He also found that women with a history of migraine with aura were 6.4 times more likely to experience full-blown panic than those without the condition. Aura was defined as seeing spots, jagged lines, or "heat waves" out of one or both eyes before the migraine.

A dysregulation of serotonin is thought to underlie both panic and migraine, according to Smoller, although not much is known about the exact nature of the neurotransmitter system malfunction in either condition, he said.

Women who screened positive for depressive symptoms were more than five times as likely to experience a full-blown panic attack, the researchers found, and those with a history of emphysema were four times as likely to experience such an attack.

In addition, women who reported a low annual income (defined as less than $20,000 a year) were 2.7 times more likely to experience full-blown panic than those who earned a higher salary. Those with three to four adverse life events in the preceding year were 4.7 times as likely to experience full-blown panic as those with no stressful life events.

Women with a history of cardiovascular disease were almost three times as likely to experience full-blown panic than those with no history of heart problems.

Smoller said he is now studying the connection between panic attack and a variety of health outcomes and whether panic attacks predict cardiovascular events, for instance.

An abstract of the study, "Prevalence and Correlates of Panic Attacks in Postmenopausal Women," is posted on the Web at <http://archinte.ama-assn.org/cgi/content/abstract/163/17/2041?>. ■

JANSSEN PHARMA-CEUTICA (A NEW TREATMENT) P4C

Forensic Coverage, Suicide Risk

Q. I recently discovered that my current malpractice policy does not cover my forensic work. Do I need liability coverage for forensic services? Are forensic services covered under the Psychiatrists' Program, the APA-endorsed Psychiatrists' Professional Liability Insurance Program (the Program)? If so, what are some of the typical services covered?

A. As more psychiatrists are undertaking forensic work, it is inevitable that lawsuits will increase in this area of psychiatry. Therefore, it is essential that a psychiatrist providing forensic services be insured by a medical malpractice insurance policy that covers these activities. Many insurance carriers classify forensic services as nonmedical because this professional activity by a psychiatrist does not involve the direct treatment or care of a patient. Thus, these insurance carriers do not cover claims arising out of forensic services. The Program, however, recognizes the specific exposures in the practice of psychiatry and includes forensic psychiatric services in the basic policy.

These are among the common areas of forensic psychiatry practice:

- Performing court-ordered child-custody and child-abuse evaluations
- Reviewing medical records for insurance companies
- Evaluating defendants in criminal cases
- Providing an expert psychiatric opinion in a civil trial on behalf of the plaintiff
- Performing fitness-for-duty evaluations for public safety agencies or licensing boards
- Evaluating housing placement of accused sexual offenders in prison systems

The Program's risk management department has developed a comprehensive article, "Risk Management Practical Pointers for Psychiatric Forensic Practice." To request a complimentary copy, please call (800) 245-3333, ext. 389, or visit <www.psychprogram.com>.

Q. A colleague was successfully sued by the family of a patient who committed suicide. I am now concerned about my own liability for the acts of my patients who are or may become suicidal. I can't predict the future, yet that's what I feel is the expectation. What risk management advice can you give me?

A. An impression shared by many psychiatrists is that to avoid liability related to treating patients with suicidal behaviors, psychiatrists are expected to be able to predict whether a particular patient will attempt suicide and thus prevent all suicide attempts, however unforeseeable. Thankfully, however, courts recognize that psychiatrists are only human; they do not expect impossible powers of prediction.

What is expected, as in any psychiatrist-patient interaction, is that the psychiatrist will meet the standard of care—that is, will exercise that degree of skill, care, and diligence exercised by members of the same profession/specialty practicing in light of the present state of medical science. In a lawsuit involving suicide, the psychiatrist's actions will be assessed by reviewing certain factors, including, but not limited to, these:

- Whether there was adequate identification and evaluation of suicide-risk indicators and protective factors for the patient with suicidal behaviors
- Whether a reasonable treatment plan was developed based on the assessment of the patient's clinical needs
- Whether the treatment plan was appropriately (that is, not negligently) implemented and modified based on an ongoing assessment of the patient's clinical status
- Whether the psychiatrist was professionally current regarding the assessment and treatment of patients with suicidal behaviors (that is, knew suicide-risk indicators and protective factors, knew current treatment options/interventions including medications, therapy, hospitalization
- Whether documentation in the patient record was adequate to support that appropriate care was provided in terms of the assessment, treatment, and monitoring of the patient

Failure to meet the legal duty to provide the standard of care to a patient is negligence. In a medical malpractice lawsuit, the plaintiff has the burden of proving that the physician was negligent. It is significant to note, however, that the standard of care is not a static concept. In any particular instance, the standard of care encompasses a range or repertoire of acceptable treatment options and requires the exercise of the psychiatrist's professional judgment. The exercise of professional judgment alone when choosing among acceptable treatment alternatives will not support an allegation of the breach of the standard of care. The standard of care in a particular case is determined by and based on that specific patient's clinical needs. Just as there is no such thing as a blanket treatment plan applicable to every patient with a given diagnosis, there is no such thing as a blanket standard of care. Testimony regarding the standard of care is provided in the discovery process or at trial by an expert witness, that is, another psychiatrist who expresses an opinion on whether the care rendered was appropriate given the circumstances.

By doing your professional best to fulfill the expectations listed above, you will be doing all you can to provide quality patient care and thus reduce your potential malpractice liability exposure.

Q. I am a participant in the Psychiatrists' Program and would like to learn more about the basics of the risk management process. What materials do you have available that would help me with this?

A. The Program's Online Education Center features many multimedia presentations for participants. From the comfort of your own home or office, you can learn the theory behind the risk management process and its associated legal concepts in a 20-minute presentation. Other topics range from "Insurance 101" to "Six Things You Can Do Now to Avoid Being Sued Successfully Later."

To reach the Online Education Center, visit <www.psychprogram.com> and log in to the "For Participants Only" section.

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. ■

apa institute

Psychiatrists Cited for Contributions To Research, Service Delivery

Each year APA recognizes individuals who advance the field of psychiatry in many different areas at its Institute on Psychiatric Services.

BY EVE BENDER

A number of psychiatrists were honored by APA at its 2003 Institute on Psychiatric Services in Boston for their outstanding work in psychiatric rehabilitation, education, and research, among other accomplishments.

These are the 2003 awardees:

- C. Edward Coffey, M.D., APA/APAA Administrative Psychiatry Award, for excellence in psychiatric administration. Coffey is vice president of behavioral health, chair of the department of psychiatry, and the Kathleen and Earl Ward chair of psychiatry at the Henry Ford Health System in Detroit.
- Jeffrey L. Geller, M.D., M.P.H., Arnold L. Van Ameringen Award, for outstanding contributions to the field of psychiatric rehabilitation. Geller is a professor of psychiatry and director of public sector psychiatry at the University of Massachusetts Medical School.
- Frederick S. Sierles, M.D., APA/NIMH Vestermark Psychiatry Educator Award, for outstanding contributions to undergraduate, graduate, or postgraduate education and career development in psychiatry. Sierles is a professor of psychiatry and behavioral sciences and director of continuing medical education in psychiatry at Finch University of Health Sciences–Chicago.
- Marvin I. Herz, M.D., APA/APF Alexander Gralnick Award for Research in Schizophrenia, for outstanding research in schizophrenia (see page 16). Herz is a professor of psychiatry at the University of Miami School of Medicine.
- Edwin J. Mikkelsen, M.D., Frank J. Menolascino Award, for significant contributions to psychiatric services for people with mental retardation. Mikkelsen is an associate professor of psychiatry at Harvard Medical School.
- Sir Michael Rutter, M.D., Marmor Award, for significantly advancing the biopsychosocial model of psychiatry. Rutter is a professor of developmental psychopathology at the Institute of Psychiatry at Kings College in London and deputy chair of the Wellcome Trust.
- Abraham J. Twerski, M.D., Oskar Pfister Award, for outstanding contributions to the field of psychiatry and religion. Twerski is the founder and medical director emeritus of Gateway Rehabilitation Center in Pittsburgh. ■

Foundation President-Elect Appears on PBS

Professional

Altha Stewart, M.D., president-elect of the American Psychiatric Foundation, appeared as a guest panelist on the PBS program "To the Contrary" on November 8. A segment of the news show, which is seen weekly by more than one million people, focused on minority mental health issues.

Stewart was part of a distinguished panel that discussed how doctors and other health care providers are attempting to destigmatize mental illness in minority communities and increase access to quality care. In addition to her role as president-elect of the foundation, Stewart is the co-chair of the APA Steering Committee on Disparities in Mental Health Care for Racial and Ethnic Minorities.

PBS decided to focus a segment of the show on minority mental health issues after learning of the foundation's recently established Minority Mental Health Awards program. This program recognizes individuals and mental health programs that are undertaking efforts to raise awareness of mental illness in minority communities and increase access to care.

The American Psychiatric Foundation is the charitable and educational subsidiary of APA focused on raising awareness of mental illness and increasing access to quality care.

More information on the foundation is posted on the Web at <www.PsychFoundation.org>. ■

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Teaching Psychotherapy

With regard to the October 3 letter on teaching psychotherapy to residents, I would like to share some experiences on developing the psychiatry clerkships for Ohio's "experimental" medical school, Northeastern Ohio Universities College of Medicine, from 1975 to 1983.

First, our "issues and purposes" group identified our basic assumptions about the nature of our students and educational mission. Our students were supposed to be Ohio's "best and brightest." This meant we should educate them to be leaders in their communities as well as solid and energetic clinicians in six primary care areas (yes, psychiatry was one of the six!). Further, we were cognizant of Robert Louis Stevenson's remark, "The physician should be the flower of civilization—such as it is. . . ."

From here it was a simple step to acknowledge the need for students to be introduced to the concept of "the interior life." Our hope was to encourage habits of reflection and greater self-knowledge ("the examined life"). A crucial corollary was the relationship of motives, feelings, and conflicts—the stuff of the interior life of the mind—to health and illness. But then what? And how to do it in eight to 12 weeks?

Luckily, in the Kent State track of the six-year program we were able to teach some philosophy in a pilot medical ethics seminar, then required in the second-year clerkship. We used interesting philosophy texts such as William Barrett's *Irrational Man* and Veatch's *Rational Man*.

Then in the weekly seminars during the fifth-year clerkship, the students read Freud's "Clark Lectures," "Mourning and Melancholia," and "The Problem of Anxiety," as well as Ian Gregory's wonderful text written specifically for medical students, *Psychiatry–Essentials of Clinical Practice*. This led to stimulating discussions of psychosomatics.

Meanwhile on the various hospital wards, we had the students shadow selected attendings, who also met with them individually to provide support. We were helped in this by the advice of our brilliant first dean and provost, Robert Liebelt, M.D., Ph.D. When we asked him, "What should we teach," he responded, "Why, just duplicate yourselves."

Since most patients were hospitalized 30 to 60 days then, the students were expected to get to know and work up one patient in detail and write up the case. We also had several sites with one-way mirrors or closed-circuit TV where students could observe psychotherapy done by selected faculty. There was no attempt to "teach psychotherapy" per se.

As I get older under the tyranny of time, I feel the need to convey to younger colleagues quickly "how we did things" before I shuffle off to Buffalo.

JOHN L. KUEHN, M.D.
Medina, Ohio

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.

Oxford Audits

I was delighted to read the letter written to the CEO of Oxford by our president, Marcia Goin, M.D., and medical director, James H. Scully Jr., M.D. The letter was timely and well researched and gave a strong message to our membership that APA is alive and well and serving its members in a responsible fashion.

I can only hope that if Oxford does not reply in a timely fashion, APA will push ahead with a more aggressive plan. Oxford committed a serious offense and, if unchallenged, could set a precedent for other companies to do the same and perhaps much worse. It is hard for our particular specialty to know when to stop trying to reason with the "other side" and instead pull out the club—which is the only tool some people and organizations understand.

F. RODNEY DRAKE, M.D.
Washington, D.C.

Dr. Drake is president-elect of the Washington Psychiatric Society.

Editor's Note: The efforts put forth by APA, the New York State Psychiatric Association, and others have been successful: Oxford Health Plans announced last month that it will stop auditing psychiatrists and mental health professionals for documentation of therapy sessions. See pages 1 and 3 for more details. ■

Profits Matter, Not Quality

It makes my stomach turn whenever I hear an HMO medical director such as Alan Muney of Oxford *(Psychiatric News*, November 7) say that the company's main concern is quality of patient care. The only thing HMOs care about is minimizing payout and maximizing profit. The perfect example is the enormous profit being made in the multibillion-dollar merger of Anthem and WellPoint Health Networks. The November 3 *Modern Healthcare* reported that one of the CEOs will pocket nearly $335 million in the deal!

It makes me furious to think of all the medicine, drug rehabilitation, home health care, and other essential services that this

please see ***Letters*** *on page 27*

Assembly

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The plans revealed a sizable opinion rift among Assembly members after they heard the proposals described at last month's meeting in Washington, D.C.

Texas Assembly representative Priscilla Ray, M.D., and Washington state representative George Vlahakis, M.D., described their respective district branch's plan to implement an "affiliate" membership category in which psychiatrists could join the district branch without becoming APA members. The Bylaws of APA and all of its district branches require dual membership.

Ray indicated that Texas decided to proceed with the plan in the hope that it will increase the district branch's declining membership. She added that the plan signals neither an intent to "de-link" or secede from APA nor "hostility" toward the national Association. Vlahakis explained that the Washington State Psychiatric Association (WSPA) does not see its plan as a "membership issue" because psychiatrists in the affiliate category will not be able to vote in district branch elections or hold office. WSPA leaders hope that affiliate members will eventually become full members, he added.

In the discussion that followed, some members spoke with empathy about trying strategies to stem the membership and revenue declines plaguing many district branches and did not express alarm about the plans' potential for weakening or dividing APA. Early in the meeting, however, APA Medical Director James H. Scully Jr., M.D., pointed out that membership numbers appear to be stabilizing.

Opponents of the plans spoke more passionately than supporters did, emphasizing the need to avoid any actions that could dilute organized psychiatry's voice or influence. One member, distressed over the proposals, cited contributions such as *DSM* and psychiatry's decades-long exemption from Medicare's diagnosis-related group payment system as examples of APA efforts that have benefited all psychiatrists, as well as their patients.

Area 4 Trustee Sidney Weissman, M.D., stressed that the most important issue at stake if APA and district branch membership are delinked is "the cohesion of organized psychiatry and the seamless link" between APA and its district branches—a link necessary if APA is to "effectively survive."

Michael Hughes, M.D., of the Florida Psychiatric Society, encapsulated the views of many Assembly members when he stated that while there is empathy in Area 5 for the Texas and Washington state plans, he hoped they would come up with another solution to their membership concerns. Implementing these plans, he stated, would amount to "radical surgery" on APA.

APA leaders continue to talk with officers in both district branches about postponing or modifying their affiliate-membership plans.

The Assembly also reviewed more than a dozen action papers, voting to

• have APA request that members voluntarily indicate their sexual orientation any time it surveys members about demographic characteristics. APA already collects voluntary information on the demographics of its other categories of minority/underrepresented members. Several Area 7 representatives objected, maintaining that APA should not be collecting such private information and warning of "unintended consequences" regarding privacy violations. Marjorie Sved, M.D., representative of the Caucus of Lesbian, Gay, and Bisexual Psychiatrists, emphasized, however, that the members she represents are the ones who asked for such data to be gathered, and that APA does not release lists of any of its members according to demographic characteristics and this would be no exception.

• ask several APA components, including those concerned with ethics and education, to address the relationship between APA, individual psychiatrists, and the pharmaceutical industry, particularly its impact on the ethical practice of psychiatry, and to draft guidelines "for the psychiatrist-pharmaceutical [industry] interface within APA."

• have APA "advocate for an industry-wide requirement that managed care organizations will collect and publish data reflecting actual access to psychiatric care" and develop model legislation legislatures can use "to ensure compliance with acceptable standards regarding access to care." The estimated cost of the proposal is $197,000.

• defeat a proposal to explore whether APA should retire the term "seriously and persistently mentally ill" and replace it with "people with mental disability." One of the authors, Roger Peele, M.D., of the Washington (D.C.) Psychiatric Society, maintained that use of the former term implies the existence of a population of psychiatric patients who aren't seriously ill. Most Assembly members, however, appeared to agree with Michael Gales, M.D., of Southern California, who argued that "disability is a very general term that has a specific medical context and that changing [terminology] to disability could cause confusion" and even be "stigmatizing."

• have APA consider supporting a change in the U.S. health care system based on the Combined Comprehensive Health Care Model, which is a "citizen/patient-owned and -directed health care system" that gives higher priority to the quality of health care services than to cost-containment.

• ask APA to establish a new corresponding

Candidates Selected For Assembly Election

At the APA Assembly's semiannual meeting last month, the nominating committee announced the names of members it selected to compete for the top two Assembly offices.

For the speaker-elect post, Joseph Rubin, M.D., of Maine, who is now the Assembly recorder, will face off against Thomas Grieger, M.D., of Virginia, the representative of the Society of Uniformed Services Psychiatrists.

The candidates vying to be the next recorder are Michael Blumenfield, M.D., a representative of the Psychiatric Society of Westchester County (N.Y.), and Jo-Ellyn Ryall, M.D., of Missouri, the deputy representative for Area 4.

The election will take place at the next Assembly meeting, which begins April 30 in New York in conjunction with APA's 2004 annual meeting.

committee composed of members from every state who have expertise in Medicaid issues. The committee would be able to facilitate and expedite information sharing between APA and district branches on the impact of budget cuts on the ability of Medicaid beneficiaries to access psychiatric care.

• urge APA to join the AMA and other groups in forcefully advocating for major changes in the way the federal government determines how much it will reimburse physicians for providing Medicare services.

• have the APA Task Force to Update Ethics Annotations revisit its blanket admonition about the ethics of psychiatrists discussing political advocacy with or soliciting research or clinical funds from patients, former patients, and patients' families. The task force suggested that such practices by psychiatrists are unethical, but the Assembly unanimously agreed that "ethics are not immutable, but evolve with the changing spirit and needs of the times, place, and world views of a particular culture and prevailing socioeconomic factors." The paper's author, New York County representative Herbert Peyser, M.D., said that in the current economic and political climate in the United States, "it might be reasonable" for psychiatrists to, for example, urge patients to advocate for quality-care issues or for or against health-related budget proposals. The paper also noted that "it would not seem unethical to solicit a contribution to fund research from a patient who benefited from sophisticated specialty care based on the work of a particular investigator or clinician."

• have the APA Committee on Psychiatric Diagnosis and Assessment discuss whether a criteria set should be developed for *DSM* that describes attention-deficit/hyperactivity disorder in adults.

The draft summary of the Assembly's actions is posted in the "Members Corner" section of APA's Web site at <www.psych.org/members/index.cfm> under "Assembly." ■

Medicare

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The provision is considered a windfall for the pharmaceutical industry, which has opposed importation of price-controlled drugs.

Now, as in the past, the Food and Drug Administration will likely continue to look the other way when individuals import small amounts of prescription drugs, but pharmacies and managed care organizations will be unable to import large quantities.

"The reality is that [the safety certification] will never happen because the secretary is never going to guarantee safety," said Bryan Anderson, press secretary to Rep. Gil Gutknecht (R-Minn.). Anderson told *Psychiatric News* that the Medicare reform law is actually more restrictive than a previous law that allows for importation of drugs from 25 industrialized countries with HHS certification of safety.

Gutknecht was sponsor of the Pharmaceutical Market Access Act of 2003 (HR 2427), which would allow importation of drugs from 25 industrialized countries—to take advantage of price controls in Europe and elsewhere—without the requirement of safety certification by the HHS secretary. That bill passed the House with bipartisan support.

Within hours of the 54-44 Senate vote on the Medicare reform bill, Senate Democratic leader Tom Daschle introduced legislation to repeal several of the bill's most controversial provisions and to allow the importation of lower-priced prescription drugs from Canada and Western Europe.

"This debate is not over; it's just beginning," said the South Dakota Democrat.

APA Medical Director James H. Scully Jr., M.D., told *Psychiatric News* that while APA had supported some of the Medicare bill's provisions and opposed others in accordance with APA policy, the Association took no position on the overall package. He underscored the bill's complex nature and still-to-be-determined ramifications.

"While the sweeping changes in Medicare embodied in the bill are inevitably controversial, and even supporters concede the bill is far from perfect, passage was strongly supported by the AMA and a large coalition of health organizations, including many specialty societies, together with patient groups such as AARP," Scully said in a member update posted on APA's Web site.

APA's Division of Government Relations will provide detailed analysis of the legislation in the coming weeks.

The AMA hailed passage of the Medicare reform bill. AMA President Donald J. Palmisano, M.D., called the vote "an important victory for Medicare patients and their physicians" and said seniors and other beneficiaries had much to cheer about.

"Seniors will receive a long-overdue prescription drug benefit, and the neediest of Medicare's patients will have no premium or deductible as well as access to medications at little cost," Palmisano said. "This historic legislation enhances patients' continued access to care by halting physician payment cuts. The House vote provides a 1.5 percent increase in payment for the next two years. For next year, this is a 6 percent turnaround at a time when physician practice costs are on the rise."

He added, "Patients also will benefit from a comprehensive package to strengthen health care in rural and underserved areas. This plan will reduce payment disparities in parts of the country where physician services are in great need and short supply." ■

letters to the editor

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one-third of a billion dollars could provide customers.

The HMOs make money by giving incentives for withholding care. They make money by coercing physicians to write preauthorizations for drugs that they don't want to pay for, until it becomes so burdensome that we simply don't prescribe them anymore. They make money by demanding exhaustive documentation to prove to their satisfaction that we are providing certain services, while knowing that we often have to forego the time-consuming extra documentation and accept lower payment so that we can use the time to ease the suffering of our patients.

We need to get these corporate leeches off our backs and the backs of our patients. We need a single-payer system.

SCOTT D. MENDELSON, M.D., PH.D.
Roseburg, Ore.