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Clinical & Research News

Prescription Data on Youth Raise Important Questions

It is no surprise that psychotropic use in those under 18 years of age has increased drastically over the last two decades. But what do these data really indicate?

BY JIM ROSACK

The reported results were, once again, not necessarily a surprise, nor were the sensationalized headlines in the popular press. However, the latest report of large increases in psychotropic prescriptions to children and adolescents over the last 10 to 15 years served to fuel hypotheses and questions regarding not only "how" but also "why."

A team from the University of Maryland–Baltimore and Johns Hopkins University School of Medicine reported in the January *Archives of Pediatrics and Adolescent Medicine* that psychotropic prescriptions written for children and adolescents in a study population totaling approximately 900,000 youths rose between 200 percent and 300 percent overall between 1987 and 1996.

"I think the main thing [about our data] is that the empirical data now back up the anecdotal data," lead author Julie Magno Zito, Ph.D., an associate professor of pharmacy and medicine at the University of Maryland–Baltimore, told *Psychiatric News*. "We have been more than aware of the fact that this [increase] has been occurring, and it is important to document that it is not just happening in one location and also that there are variations."

Zito and her colleagues analyzed computerized community treatment data on youths enrolled in three health care systems: a mid-Atlantic state Medicaid system, a Midwestern state Medicaid system, and a national group health maintenance organization. Ten one-year cross-sectional data sets were analyzed to produce yearly snapshots of prescribing of psychotropic medications in each system between 1987 and 1996.

Total psychotropic medication usage increased two- to threefold, depending on spe-

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Professional News

Minnesota DB's Success in Improving Access Not Duplicated Elsewhere

The Minnesota Psychiatric Society makes progress in solving access problems, but the crisis worsens in other sections of the country.

BY KATE MULLIGAN

Support continues to build for the efforts of the Minnesota Psychiatric Society (MPS) to help resolve the crisis in access to inpatient care in its state.

The effort began in August 2002, when MPS President Kevin O'Connor, M.D., asked Eric Larson, M.D., chair of the mental health department at Park Nicollet Clinic, to head a task force that would assess the decrease in availability of inpatient/intensive outpatient treatment programs over the last 10 years, determine the causes of the shortage, describe the harm resulting from lack of access to services, and recommend steps to alleviate the crisis (*Psychiatric News*, September 20, 2002).

The task force issued the report "The Shortage of Psychiatrists and of Inpatient Psychiatric Bed Capacity" in September 2002.

MPS President-elect Karen Dickson, M.D., told *Psychiatric News*, "The most exciting new development is that the Minnesota Medical Association [MMA] will convene a work group to promote the ideas in the report. We're delighted to have its support, which will multiply the effect of our own efforts."

MMA also passed a resolution calling for meetings of insurance representatives, state officials, psychiatrists, and other physicians and plans to call on the governor to appoint a blue ribbon commission about the problems raised in the report. Dickson is a member of MMA's board of directors.

Larson told *Psychiatric News* that HealthPartners, one of the state's three major companies, had agreed to stop "really onerous aspects of case management."

According to preliminary discussions, another company will offer parity in payment for psychiatrists and general practitioners for reimbursement of specific treatment codes. Previously, the company reimbursed psychiatrists at a lower rate than general practitioners.

The Minnesota Hospital and Healthcare Partnership, the trade association for the state's hospitals, sent the report with a letter of endorsement to the state's major insurance companies soon after it was published.

The crisis in access to inpatient care is accelerating in other sections of the country, however.

In Massachusetts, for example, as of November 1, 2002, the state stopped contributing to the cost of inpatient care for the approximately 200 uninsured Department of Mental Health (DMH) clients who are hospitalized each year with severe mental illness.

Private psychiatric hospitals had agreed to a "no reject" policy at a time when the

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Group-Practice Psychiatrists See Temporary Income Increase

Overall physician compensation increased in 2001, with a relatively small increase recorded by psychiatrists. But cuts in Medicare and increases in malpractice premiums may make that gain short lived.

BY MARK MORAN

Physicians in medical group practices saw a slight increase in compensation in 2001, according to a recent survey. But those increases are liable to disappear when the same survey reports data next year on 2002 income.

The "Medical Group Management Association's Physician Compensation and Production Survey: 2002 Report Based on 2001 Data" shows that compensation for primary care physicians rose 1.21 percent to $149,009 in 2001. Compensation for specialists rose 2.64 percent overall to $263,254.

However, the 2001 data do not reflect the impact of a 5.4 percent average reduction in Medicare reimbursements that went into effect on January 1, 2002. That reduction, and other factors in the health care market, could send doctor incomes down in 2002, say association officials.

"While vital for benchmarking purposes, the 2002 report speaks to how medical groups managed in 2001," said William F. Jessee, M.D., president and chief executive officer of MGMA. "We anticipate that the combination of the 5.4 percent Medicare reduction and the recent industrywide increases in medical liability premiums will lead medical groups to experience a far different compensation and production landscape for 2002."

Psychiatry experienced an increase of 0.65 percent in income between 2000 and 2001, and a 13.32 percent increase in income between 1997 and 2001.

Importantly, the overall compensation for psychiatrists during 2001 was higher than that for pediatricians, internists, and family practitioners. Overall, compensation for psychiatrists was $157,509, compared with $150,222 for pediatricians, and $149,702 for internists. Overall compensation for family practitioners (who do not also practice obstetrics) was $149,009.

The median income for psychiatrists in single-specialty group practices was $174,605. For psychiatrists in multispecialty practices, the median income was $160,303.

"Psychiatry is a cognitive specialty like internal medicine, pediatrics, and family medicine," APA Medical Director James Scully, M.D., told *Psychiatric News*. "It is good to note that we are at least keeping up with our colleagues in terms of income, even as we deal with the stresses currently affecting the practice of medicine. Considering the level of education and training, this relatively small increase is not likely to influence students who expect a large income to select psychiatry as a specialty. We will continue to recruit students who are intrigued by the complex illnesses and opportunities to really help people who are suffering from psychiatric illnesses."

The "MGMA Physician Compensation and Production Survey: 2002 Report Based on 2001 Data" features information for 95 physician specialties and subspecialties and 22 nonphysician provider specialties. The report uses several productivity measures: gross charges, ambulatory and hospital encounters, surgery/anesthesia cases, and total and physician work relative value units (RVUs). The report also includes ratios of compensation-to-production and compensation-per-physician work RVUs.

"Unless the Senate acts swiftly to ratify the increases legislated by the House, medical groups will be unable to effectively budget and operate in 2003."

Data were collected through survey questionnaires that were mailed in February 2002 to MGMA member and nonmember individuals in 11,440 organizations. The response rate was approximately 25 percent. As part of the data collection strategy, both printed and electronic survey questionnaires were made available.

Among specialties that were surveyed, noninvasive cardiology experienced the greatest increase in compensation between 2000 and 2001, with a 12.14 percent increase. This was followed by specialists in diagnostic radiology, who experienced a 11.41 percent increase in compensation.

Compensation also rose for nonphysician providers of health care services in group settings. Psychologists' compensation rose 2.04 percent between 2000 and 2001; the overall median compensation for psychologists in 2001 was $69,331.

Jessee emphasized that MGMA is lobbying Congress and the Bush administration to enact legislation to correct the reductions in Medicare for 2003 and beyond.

"Unless the Senate acts swiftly to ratify the increases legislated by the House, medical groups will be unable to effectively budget and operate in 2003," said Jessee. "The continued expansion of the Medicare beneficiary population will only exacerbate the need for adequate compensation for our nation's physicians." ■

Help Secure the Future Of Psychiatric Research

BY PAUL APPELBAUM, M.D.

In many respects, the advances in research in psychiatry during the last quarter of the 20th century are among the greatest triumphs of our profession. It amazes me to think of the disorders for which we now have specific, effective treatments but were essentially untreatable when I was a resident 25 years ago. If the progress is to continue, we have some challenges to overcome, and, as is true so often in psychiatry today, many of those challenges have to do with money.

Before we turn to the obstacles that we must overcome to continue our progress, consider how far we have come. At the conclusion of the Decade of the Brain—as the National Institute of Mental Health (NIMH) designated the 1990s—we had developed an array of technologies, such as functional magnetic resonance imaging (fMRI) and positron emission tomography (PET), that allowed us to peer into the living brain as we have never been able to do before. Apart from the scientific progress embodied in the findings of these new functional imaging techniques, they constitute powerful means of persuading the public and key decision makers about the reality of mental illness and its effects on the brain. And as we begin to assess the impact of treatment on brain function, the resulting images will constitute graphic depictions of the efficacy of our techniques.

In the next decade, we reasonably expect that the genomic revolution will enable us to track the pathogenic processes in many psychiatric disorders to their roots in molecular abnormalities caused by genetic variations. Though progress in psychopharmacology has often been reliant on serendipity—recall the stories of the discovery of the effects of the monoamine oxidase inhibitors, lithium, and chlorpromazine—that need not be the case in the future. We are likely to see the development of interventions targeted at pathogenic variation in protein structure and DNA that will allow better treatment, with fewer side effects, than ever before. And we may perhaps witness the first genuine preventive interventions that our field has known.

At the same time, our technologies for epidemiologic, cognitive, and social science research, along with the statistical pillars on which they rest, have also advanced markedly. We understand more about the prevalence and distribution of psychiatric illness, and about the impact of at least some environmental variables, than we ever have before. And our interventions are by no means limited to psychopharmacologic treatment: the evidence base supporting psychotherapeutic and other psychosocial interventions grows apace.

Unfortunately, the picture is not without its dark spots and premonitions of further problems to come. Although psychiatric research is flourishing, by and large it is not

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Is Loophole Shortchanging Mentally Ill Veterans?

In 1996 Congress stipulated that the Department of Veterans Affairs must "maintain its capacity" to serve veterans with serious mental illness. The VA and an oversight committee still debate what that phrase means.

BY KATE MULLIGAN

Veterans with serious mental illness and other disabilities could pay an increasingly high price for the failure of Congress to define a key term in legislation passed in 1996.

PL 104-262 states that "the Secretary shall ensure that the Department maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that affords. . .reasonable access to care and services for those specialized needs and ensures that the overall capacity of the Department to provide such services is not reduced. . . ."

Miklos Losonczy, M.D, Ph.D., told *Psychiatric News* that Congress did not define "capacity" in the legislation. He was then a member of the Committee on Care of the Seriously Mentally Ill Veteran (SMI committee), which was established by Congress to monitor and advise on the care of the groups specified in the legislation, and is now the committee's co-chair. He is also associate chief of staff for mental health and behavioral sciences at the VA New Jersey Healthcare System.

Model of Care Changed

According to Losonczy, the legislation came about because the Veterans Administration (VA, now Veterans Affairs) was about to move to a capitation model of distributing funds throughout its health care system. Advocates and others were concerned that veterans with costly illnesses and disabilities might be short-changed because of the cost advantage in treating other kinds of patients.

The VA asked the committee for advice about a definition of capacity.

That group decided that capacity should be measured by the number of veterans treated and the dollars expended for their care in specialized programs.

Losonczy said, "We assumed that the dollars would be inflation adjusted each year, as they are in other VA cost analyses."

VA staff prepares the "capacity report" and submits it to the SMI committee for comment. With one exception, the report never has reflected the impact of inflation in its analysis of dollars expended.

"Every year," said Losonczy, "we explain the importance of considering inflation to key VA officials, and we comment about it in our official memorandum about the report to the undersecretary for health. The response generally is 'We'll get back to you.' "

In the memorandum accompanying the most recent report, the committee wrote, "Dollars expended was seen as a pragmatic means to measure the intensity of service provided this special population. As a measure of intensity of service, the committee believes this is meaningful only if a reasonable adjustment for inflation is included and has consistently presented this view since the first capacity report in 1997."

VA Not in Compliance

The committee contends that the VA "is still not in substantial compliance with the capacity provisions of PL 104-262 and PL 107-135" and argues that there has been a 25 percent decline in expenditures for specialized treatment for the SMI population, using 1996 as a base.

The VA, however, in the executive summary of the report, writes, "VA maintained its national operating capacity in FY 2001 for all categories of special dis-

NIDA Starts Drug Education Early

Elementary school teachers now have at their disposal a new curriculum created by the National Institute on Drug Abuse (NIDA) to teach students about the brain and the effects of drugs on it.

The goal is to give young students a foundation for acquiring future information on the brain and drug abuse and to enable them to understand the health risks associated with drug use.

"Brain Power! The NIDA Junior Scientist Program" is geared toward second and third graders and is presented in six modules. Each module includes a video, written materials for students, a parent newsletter, and a teacher guide. In the first module students learn about the process of scientific inquiry; other modules cover brain function and the harmful effects of illicit drugs on the brain and nervous system.

Materials can be ordered free on the Web site of the U.S. Department of Health and Human Services and Substance Abuse and Mental Health Administration Service's National Clearinghouse for Alcohol and Drug Information at <www.drugabuse.gov/JSP/JSP.html>.

ability, with the exception of substance abuse. . . . On a national scale, treatment and rehabilitative capacity for all other mental health special disability categories was maintained or improved since the last capacity report."

The report is for Fiscal 2001, although it was not released to the Committee on Veterans Affairs until October 25, 2002.

Health care economist Paul Ginsburg, Ph.D., told *Psychiatric News*, "Unless one imagines sharp productivity increases, the failure to consider the impact of inflation will result in a decrease in labor resources devoted to mental health services."

Ginsburg is president of the Center for Studying Health System Change.

The committee contends that those decreases have, in fact, occurred. The report alleges that there has been a 23 percent decline in total mental health staff.

Losonczy said, "The percentage decline in staff almost exactly mirrors the percentage decline in inflation-adjusted dollars."

Veterans organizations, such as the American Legion, support the committee's contention about inflation, according to Losonczy.

Joy Ilem, assistant national legislative director for the Disabled Veterans of America, told *Psychiatric News*, "We fully support the committee's position about inflation. Year after year, we raise the issue whenever we can. The definition of capacity affects veterans with other kinds of disabilities as well and is part of the overall problem of an overburdened VA health care budget."

APA Assembly Speaker Albert Gaw, M.D., told *Psychiatric News*, "APA's Caucus on Veterans Affairs supports all efforts to maintain the capacity of the VA to provide quality care for veterans with serious mental illness. We would register a concern if a failure to consider the impact of inflation on the financial resources devoted to this population results in a deterioration of care."

Gaw is co-chair of the APA Caucus of VA Psychiatrists and medical director of the San Francisco Mental Health Rehabilitation Facility.

The means by which capacity is measured could affect the VA response to a request from Sen. John D. Rockefeller IV (D-W.Va.), then chair of the Senate Veterans Affairs Committee, according to Losonczy.

In a hearing on July 24 about mental health services, Rockefeller asked Robert Roswell, M.D., the VA's undersecretary for health, "What would it cost to do the job right?" *(Psychiatric News*, September 6, 2002).

Roswell agreed to submit a budget figure to the committee. A spokesperson for the committee told *Psychiatric News* that Roswell later had written to the committee that he would submit the figure in February 2003. ■

Army Goes Into Battle Against Soldier Suicides

When helping someone at risk for suicide, the right approach could mean the difference between life and death. Now, Army personnel can assess their intervention techniques and learn from their mistakes with cutting-edge technology.

BY EVE BENDER

The U.S. Army has in its arsenal a new weapon in the fight against suicide. So-called human interaction simulation software is helping people who are trained in suicide intervention to hone their skills and practice the intervention in real-world scenarios.

The software made its first public debut at a Department of Defense suicide prevention forum last November in which military leaders spoke about suicide prevention programs in the armed forces.

Lt. Col. Jerry Swanner, an Army suicide prevention manager at the Pentagon, talked about the Army's attempts to reduce suicide among its personnel and maintain the skill level of those who have received suicide prevention training.

The Army has been using the applied suicide intervention skills training (ASIST) model since 1989, when Army commanders, projecting mass casualties from the impending Operation Desert Storm, contracted with Living Works Education Inc., creators of the ASIST model, to lead suicide prevention workshops with the Army's V Corp in Germany. The V Corp processes and transports casualties, Swanner explained, so its troops would have been especially vulnerable to the effects of war.

Living Works Education is an Alberta, Canada–based company founded in 1991 by four mental health professionals who had been working for years to develop suicide intervention training programs for all types of caregivers. Groups who have implemented the ASIST model include U.S. and Canadian government agencies, correctional facilities, schools, and hospitals.

ASIST didn't go Army-wide until the new millennium, when the Army's Suicide Prevention Working Group decided to make the training part of its suicide prevention campaign, Swanner said.

Between 1997 and 1999, there was a 26 percent increase in the number of suicides committed by active-duty personnel, Swanner said. The rate rose from 10.6 suicides per 100,000 to 13.1 in that period. In 2001, the most recent year for which the Army has data, the rate was 9.1 per 100,000. The rate in the general population is 10.3 per 100,000. (Swanner did not speculate on why the suicide rate dropped.)

"ASIST allows us to do triage at the unit level," Swanner said. "The purpose of the training is to enable anyone—regardless of his or her training—to determine the risk of suicide and intervene to reduce this risk until the person can get to a mental health professional."

A new software package featuring "Billy" will enable Army personnel to practice their suicide intervention skills in a number of different scenarios.

During an intervention, the person trained in ASIST contracts with a person at risk to not harm himself or herself before a visit to a mental health professional. The ASIST trainee also attempts to help the suicidal person to acknowledge and utilize the supports in his or her life, such as family or friends, Swanner said.

Swanner emphasized that ASIST is "first aid for suicide"—it does not involve psychotherapy or an attempt to "fix" someone who is thinking of suicide. "It just protects the person at risk until he or she can reach a mental health professional," he explained.

Key personnel who are stationed at all Army battalions such as Army ministry teams, emergency relief counselors, "and anyone who regularly deals with soldiers who are under stress," Swanner said, attend the two-day ASIST workshops. Currently, there are about 150 master trainers throughout the Army—those who've received the training and are instructed to train others—and 3,000 Army personnel who have participated in the ASIST workshops.

"The training has been so successful that the local commanders have decided to expand it to include drill instructors," Swanner said.

Once the two-day workshop is over, however, people who have been trained in ASIST don't have much opportunity to practice their newly acquired skills. Enter the Johns Hopkins University Applied

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PHARMACIA XANAX
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Michigan Continues to Cut Public Psychiatry Beds

The trend to eliminate hospital beds for people with mental illness continues in Michigan, as that state decides to sell one of its leading psychiatric hospitals.

BY DAVID MILNE

In keeping with its practice of closing more publicly operated psychiatric hospitals than any other state, Michigan will put up for sale Northville Psychiatric Hospital, one of the last public mental health facilities in the metropolitan Detroit area. The hospital will be closed in July, and auction of the expansive property is expected to fetch at least $65 million needed to help ease the state's budgetary crisis.

Once Michigan's premier location for mental health care, Northville was built in the 1950s on 453 wooded acres where residents had access to forests and rolling hills. It had a peak capacity of 1,200, serving adults with mental illness from five surrounding counties.

News of the closing was greeted by strong reaction from advocates for the mentally ill, while township officials, neighborhood residents, local police, and land developers welcomed the decision.

In an announcement in November, Michigan Department of Community Health Director James K. Haveman Jr. said the decision was based on increased numbers of employees at Northville agreeing to an early state retirement option and initiatives local community mental health organizations had made placing patients in community settings.

The Michigan Department of Community Health is the state mental health authority.

"That the staff has gone down at Northville should be no surprise, given the early retirement program offered state employees," Mark Reinstein, Ph.D., president and CEO of the Mental Health Association in Michigan, told *Psychiatric News*. He said the legislature had budgeted the hospital enough staff for all of Fiscal 2003, but the administration didn't prevent staff from taking early retirement or make any provisions for replacing retirees.

"What health care entity in its right mind would say, 'Gee, several staff retired so we'd better shut down an essential human service for which we have been fully funded?' " he asked.

Reinstein believes that Northville was targeted because the administration of Gov. John Engler (R) wanted to tie the hands of incoming Gov. Jennifer Granholm (D) on this issue as much as possible.

He said that the state had reneged on an earlier promise that if the Northville land were sold, the state was to lease back the grounds containing the hospital and operate it for a minimum of three years.

Michigan Psychiatric Society (MPS) President Michele Reid, M.D., who is medical director of Detroit-Wayne County Community Mental Health Agency (DWC), the agency most directly affected by the closure, will be responsible for implementing planning and working with the Michigan Department of Community Health to ensure appropriate services and supports are provided for the 228 Wayne County residents at Northville. Some persons will be transferred to other state facilities. Mt. Pleasant Center, Caro Center, and Kalamazoo Psychiatric Hospital will also be options for persons requiring continued state hospitalization. When clinically indicated, others will be discharged to community and residential settings according to a person-centered planning processes.

"We expect no problems with transfers, and the state has agreed to expand funding at the Walter Reuther Hospital in Wayne County so it can open another 100 beds to accommodate Northville patients," Reid told *Psychiatric News*.

The Michigan Department of Community Health and the Detroit-Wayne County Community Mental Health Agency are being sued by Michigan Protection and Advocacy Services Inc. (MPAS) over concerns about discharge and person- centered planning.

"Our concern is that when people leave the hospital, there will be services in place that they need, but we are convinced that most people don't need to be in a long-term psychiatric hospital," Mark Cody, senior attorney for MPAS, told *Psychiatric News*.

He believes that many of the patients could have been moved out of the hospital a long time ago if adequate community services had been in place.

"There may be some people that psychiatrists would say need long-term care, but we have not seen Wayne County develop the services needed to support people in the community. That is one of the problems just now—that you have the hospital making decisions about who can go back to the community, with no understanding of what resources are available or what can be developed in the community," he said.

Reinstein said that the Northville dilemma stems from the Engler administration's view that intermediate and long-term psychiatric hospitalization have no value.

"And with Detroit/Wayne CMH turning management responsibilities over to a new 'middleman' layer of provider networks, the disincentives for community utilization of longer-term hospitalizations may be even greater than ever," he said.

But Reid said, "The Detroit-Wayne County Community Mental Health Agency is not turning its management responsibilities over to a middleman. We are complying with Michigan Department of Community Health and federal procurement requirements to allow competition for mental health services in the development of vertically integrated provider-sponsored specialty networks."

According to Reinstein, the community mental health system is so overburdened and underfunded that it has created an epidemic of mentally ill in Michigan's prisons and jails.

A study by Michigan Department of Community Health found a 50 percent rate of mental illness and a 34 percent rate of serious mental illness among jail inmates in three counties, while an older study with which Michigan State University was involved revealed that at least 20 percent of state prison inmates had serious mental illness. Yet state officials continue to claim only 6 percent of prison inmates undergo mental health treatment. The Michigan Coalition Against Homelessness found that a key contributor to a crisis in statewide shelter bed space has been "increasing numbers of people inadequately treated for mental illness."

"Michigan can scarcely afford to lose the state hospital beds at Northville," Kathleen Gross, executive director of MPS, told *Psychiatric News*. "The outgoing administration has always pointed to unfilled private psychiatric hospital beds to justify the closing of state hospitals. But many private beds licensed by the state are affected by managed care and the cash-strapped community mental health system."

Unfortunately, the private health care industry lacks the interest or funding sources to create long-term psychiatric beds, said Gross. Unlike Northville, Community Hospital beds are usually not arranged in a way to provide common space for daytime and rehabilitative programming and lack access to the out of doors. In addition, the staffing is often inadequate, with high turnover rates. She believes unionized staff at state hospitals have historically been more stable and more supportive than at most

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Menninger, Baylor Finally Tie Knot After Calling Off Earlier Wedding

The Menninger Clinic's proposal to move to Texas has taken another turn. This one appears final.

BY KEN HAUSMAN

Menninger won't be in Kansas anymore. More than two years after the renowned psychiatric facility announced a controversial decision to leave Topeka, where it has been based since its founding 77 years ago, Menninger's trustees and directors voted on December 4 to finalize the proposal to move to Houston and merge with Baylor College of Medicine and Methodist Hospital of Houston (*Psychiatric News*, November 7, 2001; November 3, 2000).

Facing mounting financial pressures in America's heartland caused by a shrinking patient base, reduced reimbursements, and shorter inpatient stays, Menninger had begun relying on its endowment to make up budget shortfalls.

In September 2000, Walter Menninger, M.D., then the president and CEO, announced that the future of the facility that bears his family's name lay in Texas in the form of a merger with Baylor and one of its teaching facilities, Methodist Hospital. He emphasized at that time that the infusion of capital the merger would bring was only one factor in Menninger's decision to relocate. He said that Baylor and Menninger shared "a simpatico philosophy and vision about dealing with the health care situation and making a difference in the world."

Kansas's governor and other state officials offered an incentive package of about $100 million to keep Menninger in that state, but the facility stuck to its guns about moving to Texas.

The Baylor psychiatry department was to be renamed the Menninger department of psychiatry, and Menninger would have the funds to expand its research endeavors greatly.

Then, in July 2001 Walter Menninger surprised observers by announcing that negotiations over the merger and move had come to an end, noting that while negotiations were "amicable," Baylor and Menninger were unable to resolve certain key differences. The explanation given for the differences was an inability to agree on money and control issues.

By the time the parties decided to go their separate ways, 13 Menninger adult and child psychiatry residents had relocated to Baylor, as had several of Menninger's most prominent psychiatrists.

Then last month Menninger released the news that its boards of directors and trustees unanimously approved a revitalized agreement to move to Houston after all.

The move is scheduled to take place in the spring and be completed by early June, according to a Menninger press release.

John McKelvey, who replaced Walter Menninger as president and CEO, noted that Baylor and Methodist Hospital are the perfect match for his facility.

"They fulfilled the required criteria, which included an internationally recognized medical center; compatibilities in cultures, treatment, and education concepts; and a strong research center with a top-ranked medical school," McKelvey said. "All of these lead to the ability to recruit world-class clinicians and researchers, and fulfill our mission. . . ."

The chair of Baylor College of Medicine's board of trustees, Corbin J. Robertson, said the board "is confident that these three leading institutions will result in the best possible research and treatment programs."

The new partnership will be accompanied by the creation of a new board of directors, with 50 percent of the representation coming from Menninger, 25 percent from Baylor, and 25 percent from Methodist Hospital. In addition, a new charitable foundation will support the clinical activities of the new Menninger Clinic and the research and educational activities of the Menninger Department of Psychiatry at Baylor College of Medicine, according to a Menninger press release.

All of Menninger's assets in Topeka will be sold, including its 500-acre campus. Menninger's current staff will not lose their jobs as long as they are willing to relocate to Houston. The staff had already been pared from about 650 employees when the merger was originally announced to 250 today. There has also been a major restructuring of Menninger's management and operations in the intervening two years. The greatly reduced staff and restructured management appear to have been critical factors in arriving at the final agreement.

All parties agreed that they would not release details of the financial arrangements. ■

New Guidelines Will Help Avert E-Mail Crash

Medem Inc., an online physician network founded by the AMA, APA, and other medical societies, announces new guidelines for doctor-patient electronic messaging.

BY CHRISTINE LEHMANN

Computer-savvy patients want to e-mail their physicians about routine matters, but physicians are reluctant to use standard e-mail because of the lack of security, liability risk, and lack of reimbursement, according to recent physician surveys.

Two recent announcements from Medem Inc., an online physician network based in San Francisco, may entice more physicians to try online communication with patients.

The company, which was founded in 1999 by the AMA and a number of medical specialty societies including APA, recently announced new guidelines for physician-patient electronic messaging. CEO Edward Fotsch, M.D., told *Psychiatric News* that the guidelines were developed by the eRisk Working Group for Healthcare, a consortium of medical societies, including the AMA, medical liability insurers, and the Federation of State Medical License Boards.

"It was important to develop uniform guidelines given recent actions by state medical boards against online physician networks and the risk of liability," said Fotsch.

Physicians in North Carolina and Illinois have been ordered by state medical authorities to stop prescribing for patients they never saw, according to Fotsch.

The most recent action was taken by the Illinois Department of Professional Regulation against MyDoc.com. MyDoc.com is owned by Roche Diagnostics, a division of Hoffman-LaRoche, a pharmaceutical firm in Switzerland.

"Our eRisk guidelines specifically state that physicians should use e-mail only with patients they have already evaluated in person and not for emergencies," said Fotsch.

The eRisk guidelines urge physicians to use secure online networks that provide encryption and identity verification. These features protect patients' privacy and enhance compliance with the federal privacy rule mandated under the 1996 Health Insurance and Portability and Accountability Act. Physicians have until April 15 to comply with the rule.

The guidelines urge physicians to use the informed consent process with patients to review appropriate uses and limitations of online communication. Medem has an informed consent form integrated in its Online Consultation Terms of Service process. "Patients must consent online; otherwise, they can't use our e-messaging service," said Fotsch.

A handful of online physician networks including Medem and RelayHealth in the San Francisco area provides physicians with secure networks using encryption. Jason Wong, Medem's network director, told *Psychiatric News* that encryption technology encodes messages sent to recipients so that unauthorized users can't understand them.

"This is also more secure than standard e-mail because messages remain on the company's server rather than travel between servers owned by different companies," said Wong.

Harold Rauch, M.D., a child and adolescent psychiatrist in Austin, Tex., and an APA member, told *Psychiatric News* that he has been using Medem's Online Consultation service for nearly a year. That is the latest feature Medem added to its secure messaging tools that patients use typically to request appointments and prescription refills, according to Fotsch.

Rauch said, "Medem is free to APA members. But, the most important factor in influencing my decision to try Online Consultation was the increased network security.

"I also decide whom I should grant e-messaging privileges to. Medem requires physicians to verify a patient's identity as part of the authorization process. I also must decide whether or not that particular patient is a good candidate to use Online Consultation."

Physicians using Medem's Online Consultation charge patients an average of $25 for each e-mail visit, said Fotsch. Rauch said he charges between $12.50 and $25 for an online consultation, depending on the complexity and time involved.

"I charge a fee for the consultation with few exceptions because I want to convey to patients that this is a professional service and discourage them from overuse," said Rauch.

He doesn't charge one patient who uses Online Consultation to transmit a daily journal of how he copes with psychosocial stressors at work. "I see this patient only once a month, and his online diary allows me to keep up with how he is coping and respond if needed," said Rauch.

"Our eRisk guidelines specifically state that physicians should use e-mail only with patients they have already evaluated in person and not for emergencies."

He also doesn't charge another patient to use Online Consultation daily. "The patient has severe depression and lives too far away for daily office appointments. This allows us to maintain daily contact," said Rauch.

Other benefits of Online Consultation are decreased telephone time with patients, increased documentation in the patient's chart, and more time to evaluate the problem and formulate a carefully worded response, he said.

"My patients use Online Consultation because it provides an alternative to an often busy telephone system and scheduled appointments for nonemergency contact with me. Another use is to document ongoing stressors in patients' lives that don't require immediate physician contact," said Rauch.

He covers conditions of online use with patients during his informed consent process. "I tell them my response time may take between 24 and 48 hours and that urgent requests for help have to be made through traditional channels," said Rauch.

The eRisk Working Group on Healthcare's Guidelines for Online Communications are posted on Medem's Web site at <www.medem.com/corporate/corporate_Addendum_A_eRiskGuidelines.cfm#medem_erisk>. ■

No Short-Term Resolution in Sight For Malpractice Insurance Crisis

Among the confluence of factors causing a startling rise in medical malpractice premiums are multimillion-dollar jury awards and financial decisions made by insurers in flusher times.

BY MARK MORAN

Protests by physicians in Pennsylvania, West Virginia, and elsewhere in the country over rising malpractice insurance fees appear to reflect a mounting crisis heralding a more vigorous call for tort reform.

And although psychiatrists do not appear to have been prominently involved in the most publicized protests—in which some physicians have threatened to stop work or cut back on services, and hospitals threatened to stop elective procedures and limit emergency room operations—experts in psychiatric liability say it is a crisis that affects doctors of all specialties.

"These protests reflect the tension among all physicians regarding malpractice," said Alan Levenson, M.D. "Whatever their specialty and whatever their practice setting, physicians are feeling the impact of very significant changes in the medical malpractice world. Premiums are going up, carriers are pulling out of the market, and in many states they have stopped underwriting medical malpractice insurance. Other carriers are tightening up their requirements and restrictions relating to whom they provide coverage for."

Levenson is president and chief executive officer of Psychiatrists Purchasing Group, which sponsors the APA-endorsed Psychiatrists' Professional Liability Insurance Program (PLIP).

Approximately 7,000 members are covered under PLIP.

Levenson said premiums under the PLIP, after several years of stability, rose an average of 30 percent last year. He said the increase was related to market conditions affecting all of medical malpractice insurance. Rates vary markedly by geographic location (see graph). He added that for psychiatrists, the nature and setting of practice are critical. Those practicing in correctional facilities or community mental health centers—where the risk of malpractice is perceived as high—may be faced with especially steep increases in premiums, Levenson said.

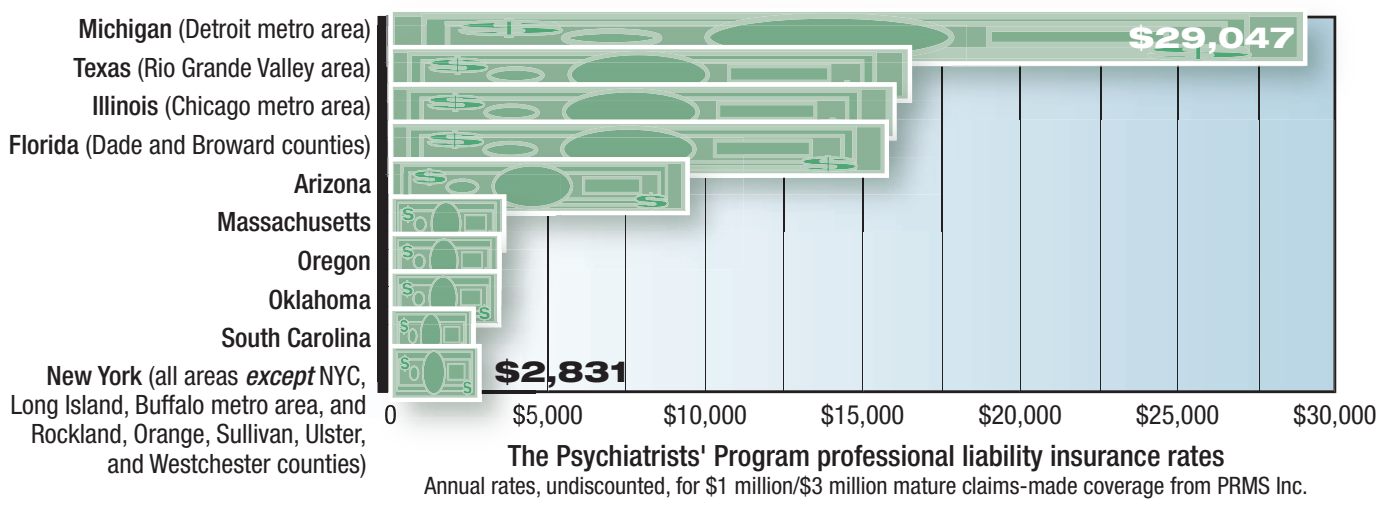
According to the American Medical Association, some specialties—including surgery and obstetrics-gynecology—are expected to experience increases of as much as 50 percent this year.

The crisis has also prompted a response from the White House. Speaking at the University of Scranton in Pennsylvania last month, President Bush lamented the litigiousness of American society and called for a $250,000 cap on noneconomic damages.

"Excessive jury awards will continue to drive up insurance costs, will put good doctors out of business or run them out of your community, and will hurt communities like

please see ***Malpractice*** *on page 39*

Location, Location, Location...



The Psychiatrists' Program professional liability insurance rates
Annual rates, undiscounted, for $1 million/$3 million mature claims-made coverage from PRMS Inc.

Source: Professional Risk Management Services Inc. (PRMS)

Ecstasy Message Appears To Be Sinking In

More students are backing away from drugs such as Ecstasy, survey results show, as they realize how serious the health risks are.

BY EVE BENDER

Extensive and persistent efforts to prevent substance abuse are likely behind declines in the use of illicit drugs such as Ecstasy and consumption of alcohol and tobacco among teens, data from the 2002 Monitoring the Future Study show.

The findings from the annual survey of eighth, 10th, and 12th graders were released at a December press conference in Washington, D.C.

Researchers at the University of Michigan's Institute for Social Research began conducting the survey in 1975 to measure self-reported drug use and perceived risk of drug use among high school students.

In spring 2002, researchers surveyed 43,700 students, including 15,500 eighth graders, 14,700 10th graders, and 13,500 12th graders at 394 private and public secondary schools across the United States.

Ecstasy Trend Reverses

Ecstasy use, which had been climbing since 1996 when researchers first included it in the survey, dropped among students at all three grade levels.

For instance, the proportion of seniors who reported using the "club drug" at least once in the preceding year peaked in 2001 at 9.2 percent, and 7.4 of percent seniors used Ecstasy last year.

Glen Hanson, D.D.S., Ph.D., acting director of the National Institute on Drug Abuse (NIDA), which funds the survey, explained the reasons behind the turnaround in usage rates at the press conference. "Attitudes toward this drug are changing, and attitudes are often the harbinger for change in rates of use."

The 2002 survey found that 52 percent of 12th graders believe people are "at great risk" for harming themselves by trying Ecstasy—an 18 percent jump since researchers first posed the question to seniors in the mid-1990s.

One of the more common drugs of abuse, marijuana, lost popularity among students last year, but only among 10th graders did the decrease reach statistical significance. About 30 percent of the 14,700 sophomores used marijuana at least once during the preceding year—down from the 1997 peak of 34.8 percent.

The percentages of students who used any illicit drug during the past year in the eighth grade (17.7 percent) and 10th grade (34.8 percent) fell slightly to match the lowest levels reported since 1993 and 1995, respectively.

The use of several drugs, including heroin, cocaine, and steroids, remained steady between 2001 and 2002. Rates neither rose nor fell significantly, according to study results. About 5 percent of seniors reported using cocaine during 2001 and 2002.

Alcohol and tobacco are also declining in popularity among these adolescents. Alcohol use dropped by 2 to 3 percent for each of the three grades from 2001 and 2002. In 2002, 71.5 percent of seniors, 60 percent of sophomores, and 38.7 percent of eighth graders said they had consumed alcohol in the previous year.

The Great Smokeout

Researchers saw the most dramatic declines in cigarette use, especially for young students. Smoking rates among eighth graders in 2002 (10.7 percent) are just half of what they were in 1996.

Between 2001 and 2002, the proportion of students who reported ever having smoked fell about 4 percent to 5 percent in each of the three grades surveyed.

Principal investigator Lloyd Johnston, Ph.D., attributed a number of reasons to the drop, such as the avalanche of lawsuits against and negative publicity about the tobacco industry, which has resulted in fewer cigarette ads.

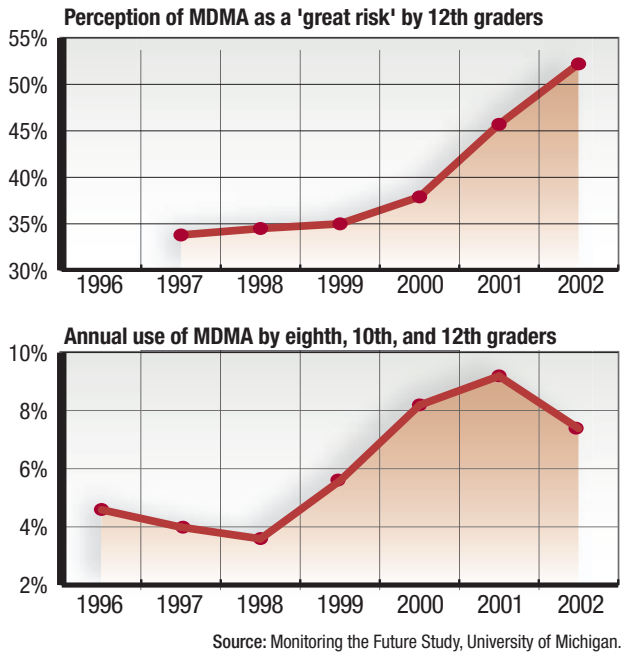
He also pointed out that attitudes toward smoking among students are changing. "When you become a smoker, you make yourself less attractive to the majority of adolescents of the opposite sex—75 percent of our young people said they would prefer to date nonsmokers," Johnston said.

Any September 11 Effect?

Regarding the overall decreases in drug and alcohol use from 2001 to 2002, Johnston wondered whether the terrorist attacks of September 11, 2001, may have had a "sobering" effect on the nation's young people, though there are not yet any data to support this hypothesis.

please see ***Ecstasy*** *on page 38*

More Teens Recognize Risk, Fewer Use Ecstasy



Source: Monitoring the Future Study, University of Michigan.

Findings from Monitoring the Future surveys show that as perceived risk of Ecstasy use increased in 2001 and 2002, actual use of the drug declined.

Proving What Works Is Challenge For N.Y.C.'s New MH Director

Lloyd Sederer, M.D., begins his career in public psychiatry at the top, as New York City's first executive deputy commissioner for mental hygiene. He explains how he is approaching his new job.

BY KATE MULLIGAN

Lloyd Sederer, M.D., had already set a daunting challenge for himself and his new staff when he became New York City's executive deputy commissioner for mental hygiene last July.

He is the first occupant of the position, which was created because New York City residents had voted the previous November to merge the city's Department of Mental Health, Mental Retardation/Developmental Disabilities, and Alcohol and Substance Abuse Services (DMH) with its Department of Health and to mandate that an executive deputy commissioner have responsibility for those three areas. Previously he was director of APA's Division of Clinical Services for two years.

"When I talked to city officials about taking the job," Sederer told *Psychiatric News*, "I proposed that the agency take the next step in its development. It should establish methods and procedures to identify and report on who is being served and the treatments and services they are receiving."

The agency needed to accomplish those basic tasks to advance to a more sophisticated set of evaluation and planning activities, he explained.

"Ultimately," Sederer said, "we want to know which services are evidence based or otherwise represent good practices and what outcomes are being achieved, in order to improve rehabilitation and recovery opportunities for New Yorkers."

The effort is complicated by the fact that the DMH does not provide direct services, but instead "plans, purchases, and monitors" services provided by other entities.

DMH has an annual budget of approximately $750 million, with which it supports 900 programs in the five boroughs of the city. Each year approximately 365 contracts with service providers are in place. A separate entity, the Health and Hospitals Corporation, has jurisdiction over inpatient psychiatric hospital care in the city's public hospitals.

Sederer said, "We are working with our service providers to foster a climate that encourages the use of meaningful measures to collect data on results. Our goal is to make the process and information understandable to key constituencies such as consumers and their families."

The effort is particularly important now because of budgetary pressures, he argued. If budgets are cut or remain constant, it will be critical for those concerned about mental health and other related services to have the capability of identifying programs and other funded activities that provide value.

Sederer has had a long-standing interest in the development of outcome measures that reflect patient experience with care and also permit practitioners to understand the impact of what they do and recognize opportunities to improve.

While medical director of McLean Hospital in Belmont, Mass., he and his colleagues developed a clinical quality measurement system for hospital services, and it has been adopted by institutions throughout the country and abroad.

Sederer and his current staff also undertook an epidemiological study that produced preliminary estimates of the need for various services among different population groups in New York City.

In addition to providing data essential to planning efforts, the study will help Sederer educate key constituencies about the economic cost of psychiatric and substance abuse disorders.

"The effort has been well received," he said, "but we all recognize that we must do more work to produce data that effectively capture the unique need for services in our city. For example, we are developing ways of incorporating the impact of 9/11 on service needs of New York City residents. I knew the job would be tough," but he also believes his past experiences have helped him meet the challenge.

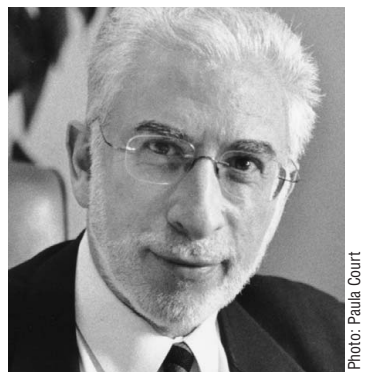


Photo: Paula Court

Lloyd Sederer, M.D.: "My years at APA offered a kind of graduate school education in health policy, quality standards, and reimbursement issues."

He said, "I take an old-fashioned approach to the question of preparation and training for a job like mine. Learning how to be a good doctor should be anyone's first and most important goal, then try to understand what's involved in giving quality care in a complicated institutional setting that is affected by reimbursement rates and other external issues."

Knowledge of epidemiology, biostatistics, health services research, and health economics also helps, but he said, such knowledge does not have to be gained in a classroom and encouraged potential administrators to learn from experts around them.

Sederer said, "My years at APA offered a kind of graduate school education in health policy, quality standards, and reimbursement issues." ■

Residential Drug Treatment Found to Be Good Value

By considering factors such as the number of days that individuals with substance abuse disorders spend in illegal activities, researchers find that residential drug abuse treatment programs show "economic benefit."

BY KATE MULLIGAN

Researchers found that the benefits of residential drug abuse treatment exceed costs by a factor of 4 to 1 in five programs in Washington state, when they used a benefit-cost analysis that considers societal costs.

Michael T. French, Ph.D., Helena J. Salome, and Molly Carney, Ph.D., used recently developed methods and guidelines for using the drug abuse treatment cost analysis (DATCAP) and the addiction severity index (ASI) to estimate the economic costs and benefits in five programs in Washington state that serve patients in publicly funded programs.

Their report, "Using the DATCAP and ASI to Estimate the Costs and Benefits of Residential Addiction Treatment in the State of Washington," appears in the February issue of *Social Science and Medicine*.

Carney is a research scientist at the Alcohol and Drug Abuse Institute at the University of Washington, and French is a professor of health care economics at the Medical University of South Carolina. Salome is a Ph.D. candidate at the University of Miami.

"The average economic cost of treatment for this sample of residential clients in Washington state was $4,912. The average economic benefit was $21,329. The average net benefit of treatment was $16,418, and the benefit-cost ratio was 4.34," they pointed out.

Data from the Office of Applied Studies suggest that approximately 70 percent of the total cost of addiction treatment in the United States is funded through public budgets.

According to the article, "the average cost of residential addiction treatment is about 5.69 times higher than the cost of outpatient nonmethadone services."

So, according to the researchers, the value of residential addiction treatment is being reappraised by many state agencies.

Researchers estimated the economic cost by using the DATCAP, which was administered on site at each of the five residential programs. They determined treatment outcomes by analysis of client-specific baseline and follow-up data collected through the ASI.

The researchers derived estimates for average weekly and total cost of addiction treatment, total benefit of treatment, net benefit of treatment, and the benefit-cost ratio.

Benefit-cost analysis, they argued, is different from cost-effectiveness analysis and preferable to it when different outcomes of the treatment intervention must be included and programs with different goals or effects must be compared.

Benefit-cost analysis "compares the opportunity cost of an intervention to the total benefit, while expressing both in a common monetary metric. Benefit-cost measures include a benefit-cost ratio (i.e., benefit divided by cost) or simply a net benefit estimate (i.e., cost subtracted from benefit)."

Economic benefits were derived from patient self-reported information collected at the beginning of treatment and six months after discharge from the program.

The researchers converted the following ASI measures into dollar-equivalent values for the benefit analysis: inpatient medical days, inpatient psychiatric days, residential addiction treatment days (follow-up only), days experiencing medical problems, income received from employment, days engaged in illegal activities, and days experiencing psychological or emotional problems.

Reported number of days engaged in illegal activities was used to estimate the reduction in crime-related costs.

The researchers used multivariate regression models to determine which client and/or treatment characteristics were significantly related to economic cost and benefit.

Robert Rosenheck, M.D., director of the VA Northeast Program Evaluation Center and a professor of psychiatry and public health at Yale School of Medicine, told *Psychiatric News*, "This is a very important type of study, but one which, as the authors note, must be interpreted cautiously for two reasons. First, since there was no control group, we cannot be certain that the cost savings were the result of treatment. They may reflect the fact that improvement can come about as a result of some natural recovery process in people who have decided to get help. Second, although measuring the economic value of health gains theoretically is very important, practically such measurement is very hard to accomplish." ■

Police Taught Proper Response To Mentally Ill Suspects

A new program is aimed at ensuring that members of Detroit's police force know how to deal with people suffering from mental illness and other disabilities with care and respect.

Detroit police will now receive training on how they should deal with handicapped, mentally ill, and homeless citizens as part of a program for more sensitivity and accountability. The first sweeping changes to the Detroit Police Department's general orders in 30 years mandate that officers put special emphasis on citizen safety and call for more training in communicating with and handling people with disabilities, including mentally ill or deaf people.

"I'm pleased to hear of these changes," Mark Reinstein, Ph.D., president of the Mental Health Association (MHA) in Michigan, told *Psychiatric News*. "This is necessary and important training that will benefit peace officers and the people they come in contact with. The possibility of hostile confrontation will be lessened, and perhaps consumers will have a better chance of being diverted from incarceration to an appropriate human service resource."

The changes, covered in a 1,000-page manual, address how and when officers should fire their weapons and how they should act during arrests and police chases, among other topics.

The new guidelines come at a time when the 4,200-member force is under a federal investigation sparked two years ago by mistreatment of prisoners and witnesses, missing drug evidence, and a number of questionable shootings by Detroit police officers, including that of a deaf, mentally ill man who was killed after threatening officers with a garden rake. The city has paid out $123 million in 13 years stemming from successful lawsuits against officers and officials who broke the rules.

"Some officers are from the old school that taught to take action first," Clarence Porter of the Wayne County–National Association for the Mentally Ill told *Psychiatric News*.

"They believe that if anyone, including a mentally ill person, picks up any kind of weapon—no matter what it is—they should blow them away," said Porter, who has helped educate Wayne County employees about people with disabilities and the mentally ill. His two-day class is attended by members of the state police, sheriffs, jail workers, and airport and university police.

"The police training manual allots only one hour for this type of training, but we say that is not enough," Porter added. Now recruits at the police academy are given a six-hour training session on sensitivity toward people with disabilities.

The Detroit-Wayne County Community Mental Health Agency and the National Alliance for the Mentally Ill-Michigan (NAMI) have a curriculum for training the law enforcement community that has been developed over the past eight to 10 years, according to Michele Reid, M.D., president of the Michigan Psychiatric Society and medical director of Detroit-Wayne County Community Mental Health Authority. More than 900 professionals representing more than 30 law enforcement organizations in Wayne County have been trained as a part of the agency's and NAMI's campaign to reduce the stigma of mental illness and developmental disabilities and to work with community partners to improve access to needed mental health services.

The new guidelines and training were unanimously approved by the Detroit Board of Police Commissioners.

Officers will be required to follow tighter rules regarding the use of force. They are now prohibited from shooting at suspects in moving vehicles, which was allowed under the old guidelines. Officers will now be expected to exercise better judgment when deciding whether to carry out high-speed car chases of suspects. Under a new domestic violence policy, officers will receive more training to deal with disputes between family members. The old rules did not require officers to receive any domestic violence training. The new policy will call for Detroit police officers to abide by state laws when dealing with domestic violence situations, a provision not previously included.

"I think this would help," Hubert Huebl, M.D., president of National Alliance for the Mentally Ill-Michigan, told *Psychiatric News*. "Anything that is done to try to educate police on how to react and deal with the mentally ill would be to the good.

"Oftentimes police are called when someone is out of control, and sometimes they might act inappropriately. But it is not their fault because they are not familiar with how a mentally ill person might act."

Police Chief Jerry Oliver, hired this year by Mayor Kwame Kilpatrick with orders to clean up the police department, promised more changes are on the horizon.

"The new policy changes were long overdue," Oliver said. "In the future, more changes will be made, and guidelines will be expanded, with more extensive training for police officers." ■

Business-Academic Partnership Ensures Mental Illness No Employment Barrier

People with mental illness are regaining their lives with the help of a nationwide employment program in which jobs are custom tailored to a person's needs and strengths.

BY EVE BENDER

A collaboration between a well-known corporation and a research center in New Hampshire is helping people with mental illness across the country to become productive members of the workforce.

The Johnson & Johnson-Dartmouth Community Mental Health Program began in July 2001 when Johnson & Johnson, the Brunswick, N.J.–based health care product manufacturer, approached researchers at the New Hampshire-Dartmouth Psychiatric Research Center (PRC) with the desire to assist people with mental illness in the recovery process.

Dartmouth had long been a source of research on supported employment services for people with serious mental illness. Researchers such as PRC Director Robert Drake, M.D., and Deborah Becker, M.Ed., senior project director, conducted a number of studies on supported employment services and developed a model for supported employment based on their findings. For instance, when asked about competitive employment, 70 percent of people with mental illness say they want to work, yet only 15 percent are employed, and people with mental illness who have received supported employment services report better self-esteem and feel more able to manage their symptoms.

According to Rick Martinez, M.D., the medical advisor to Johnson & Johnson's Office of Corporate Contributions and Community Relations, "We selected the Dartmouth Psychiatric Research Center because the researchers there have been so successful in establishing an evidence base for the supported employment of people with serious mental illness—an intervention that can help people turn disability checks into paychecks."

The joint venture began with a $200,000 grant to develop pilot programs in supported employment at community mental health centers at three sites: Montpelier, Vt., Hartford, Conn., and Sumter, S.C. Since that time, Johnson & Johnson has donated more than $1 million to the program, which has expanded to include four additional sites in Maryland, Kansas, Washington, D.C., and Oregon. States are asked to match funding from Johnson & Johnson to help run sites, but this is not always possible.

The sites adhere to the six principles of supported employment (see box at right) that have been shown to produce good employment outcomes and forge a close relationship between vocational rehabilitation programs and community mental health centers in those states.

According to David Lynde, M.S.W., program manager for the New Hampshire-Dartmouth PRC, the close collaboration is part of an integrated approach in which the mental health treatment team at each site, usually including a psychiatrist, psychiatric nurse, social worker, and case manager, works with an employment specialist from the mental health center or a state vocational rehabilitation program to find jobs for people with mental illness.

"The members of the team support the client's employment goals and communicate with one another about the client's needs and strengths," he said. "Together, they problem solve and address any problems that may come up with the client in his or her work situation."

When a client of the community mental health center expresses an interest in finding work, the employment specialist completes a "vocational profile" on that person by first inquiring about his or her needs, strengths, employment history, and job preferences, for instance. Not all clients receiving services at the community mental health centers opt for employment, however. Employment specialists in the program typically offer their support at all stages of the employment process. They may accompany the client to job interviews, submit job applications to the prospective employer, or talk to prospective employers about the program and clients ahead of time with or without the client.

"We develop jobs," said Jeemy Grate-Pearson, who is an employment specialist at the site in Sumter, S.C.—better known as the Assertive Community Treatment/Individual Placement and Support program under the Santee-Wateree Department of Mental Health. "We usually don't have a job waiting for a client when he or she walks in the door."

Grate-Pearson explained that if there is a full-time position open somewhere but the client does not want to work on a full-time basis, job sharing among two people is possible. Or if someone wants to work in a certain store but has difficulty with lots of commotion and noise, "we might talk to the employer about the possibility of hav-

please see ***Employment*** *on page 38*

Success Stems From Six Principles

According to the model established by researchers at the Dartmouth-New Hampshire Psychiatric Research Center, evidence-based supported employment for people with mental illness must adhere to six basic principles to be successful:

- Individual preferences and goals are given high priority. Choices and decisions about types of employment and support are individualized and based on the person's preferences, strengths, and experience.
- No one is excluded from a supported employment program because of a history of hospitalization or substance abuse, active psychiatric symptoms, or lack of prior work experience.
- Supported employment services are integrated with other mental health services. Employment specialists work closely with the mental health treatment team to support the client's work goals.
- The goal is to assist people in obtaining meaningful jobs in the community that pay at least minimum wage.
- Supported employment services begin shortly after a person has expressed an interest in participating. Individuals need not submit to a lengthy pre-employment assessment or vocational testing.
- Supported employment services are provided on a continuous basis, at all steps of the employment process, to help people keep their jobs or move on to other jobs if they choose. These supports are in place for as long as they are needed.

APF Appoints Five To Board of Directors

The leadership of the American Psychiatric Foundation is committed to identifying resources that will enable it to live up to its mission of improving the lives of mentally ill people and their families.

BY MEGHAN SAYER

The American Psychiatric Foundation announced the reappointment of John S. McIntyre, M.D., and Altha Stewart, M.D., and the appointment of Maria Llorente, M.D., Janet Vergis, and Joseph Zumpano, J.D., to three-year terms on its board of directors.

These appointments, which became effective January 1, represent the foundation's continuing commitment to build a diverse Board of Directors who bring a variety of experiences and viewpoints to the organization.

McIntyre is chair of the department of psychiatry and behavioral health at Unity Health System in Rochester, N.Y., and a clinical professor of psychiatry at the University of Rochester School of Medicine and Dentistry. In addition to having served as a president of APA, he was speaker of the APA Assembly and now serves as chair of the APA Steering Committee on Practice Guidelines and the APA Political Action Committee (APAPAC). He is also the new APA senior delegate to the AMA House of Delegates and chair of the AMA Section Council on Psychiatry.

Stewart recently stepped down as executive director of the Detroit-Wayne County Mental Health Agency to return to private practice and teaching. She is the incoming president of the Association of Women Psychiatrists and a former president of the Black Psychiatrists of America. She is also chair of the APA Council on Social Issues and Public Psychiatry.

Llorente is director of geriatric psychiatry at the VA Medical Center in Miami. She recently was a member of the board of trustees of the American Society of Hispanic Psychiatrists and served as chief of the division of geriatric psychiatry and training director of the department of psychiatry and behavioral sciences at the University of Miami School of Medicine.

Vergis recently was named vice president for global strategic marketing for Johnson & Johnson after serving as vice president for the CNS Franchise for Janssen Pharmaceutica, a subsidiary of Johnson & Johnson. She began her career as a clinical researcher before moving into marketing for Ortho-McNeil Pharmaceutical and Janssen. Vergis received the 2000 YWCA Tribute to Women in Industry Award for significant professional and community contributions and participates in the Johnson & Johnson Mentoring Program.

Zumpano is a noted health care attorney from Miami. He is chair of the health care practice for the law firm of Ferrell, Schultz, Carter, Zumpano, and Fertel. Zumpano is active in the South Florida community, dedicating time and skills to a range of local organizations, including the Junior Orange Bowl Committee, the Coral Gables Community Foundation, and the New Leadership Division of the State of Israel Bonds.

"We are please that Drs. McIntyre and Stewart will continue to provide leadership to the organization," said Foundation President Abram M. Hostetter, M.D. "They have been instrumental in guiding the organization through a period of transition and growth.

"The addition of Maria Llorente, Janet Vergis, and Joe Zumpano will bring fresh perspectives to the organization from the research and provider communities. We look forward to working with them over the coming years as we chart the future direction of the foundation."

The American Psychiatric Foundation is a charitable and educational subsidiary of APA. Its mission is to improve the lives of patients and their families, as well as their communities, through support of education, advocacy, and research advancing the prevention and treatment of mental disorders. ■

Ms. Sayer is a development officer at the American Psychiatric Foundation.

APA Members Urged to Volunteer As Screeners

On the heels of scientific evidence proclaiming the health benefits of daily alcohol consumption, psychiatrists and others are asked to screen Americans for excessive alcohol intake.

BY EVE BENDER

Psychiatrists and health professionals are being asked to screen people for alcohol abuse or dependence in April and educate the public about the many health problems that can result from frequent alcohol use.

The fifth annual National Alcohol Screening Day (NASD), which is funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the Substance Abuse and Mental Health Services Administration, takes place on April 10 and coincides with Alcohol Awareness Month.

Last year, professionals at about 2,800 sites screened more than 45,000 people.

APA is one of about 30 organizations that sponsors the event.

NASD is organized each year by Screening for Mental Health Inc., a nonprofit organization based in Wellesley Hills, Mass.

According to NIAAA, almost 14 million Americans either abuse alcohol or are alcohol dependent. Heavy drinking increases the risk for an assortment of health problems such as high blood pressure, certain types of cancers, heart disease, and birth defects.

To educate the public about the many health problems associated with alcohol in-

please see ***Screening*** *on page 17*

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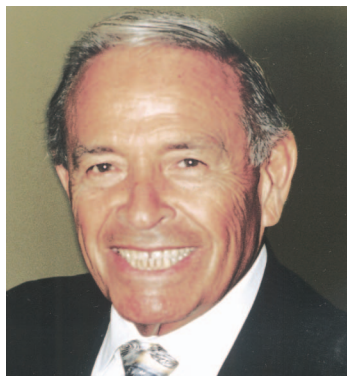
Time of Transitions

BY JAY B. CUTLER, J.D.



This final "Capitol Comments" article under my byline marks a number of significant transitions, both internal to APA and to our advocacy for psychiatry on Capitol Hill, in the executive branch, and in support of our district branches and state associations across the country.

Just a few weeks ago James Scully, M.D., became APA's new medical director, and the Association moved its headquarters from downtown Washington, D.C., to Arlington, Va. Your APA staff did a magnificent job in making this a smooth move, and we are now busily sorting through myriad boxes and crates and getting situated in our new quarters. Your "Team DGR" was ready as the 108th Congress convened with single-party control of the House, Senate, and the White House. The Senate convened with a new majority leader, Sen. Bill Frist (R-Tenn.), who is a physician.

Mr. Cutler stepped down as director of APA's Division of Government Relations last month. He is now a consultant to APA.

On a personal note, effective January 1, I stepped down as director of APA's Division of Government Relations (DGR), although I am pleased to let you know that I will serve as a political/government relations/advocacy consultant to Dr. Scully and APA. For more than 20 years, it has been my great privilege to serve APA as the chief advocate for psychiatrists and their patients with Congress and the executive branch in Washington, D.C., and to assist you in your work on behalf of your patients and psychiatry at the state level.

Much has transpired in my 20 years at APA. Insurance coverage of mental illness has significantly improved. Thanks to your tireless advocacy, more than 30 states have enacted some form of nondiscriminatory health-insurance requirement. Working together, we have witnessed the federal maximum share of Medicare coverage of treatment of mental illness go from a nearly nonexistent $250 afterthought to a meaningful outpatient benefit. Congress enacted and the president signed a national nondiscriminatory coverage law requiring equality of lifetime and annual dollar limits between mental and other medical/surgical care. The national research budget devoted to biomedical and behavioral research on mental and addictive disorders has dramatically increased. Treatment options exist today that were not even dreamed of when I first joined APA. Psychiatry works in mainstream partnership with the AMA and all of medicine, with our patient advocacy groups, and, wherever possible, with other institutional and mental health groups.

What is most striking and personally gratifying is not the gradual easing of barriers to treatment, but the extraordinary degree to which the public and our political leaders have come to embrace our advocacy supporting the effectiveness of mental illness treatment and equal access to care as a matter of basic rights. When I started at APA, we were hard pressed to find any senators and representatives who would openly support our legislative agenda. Today, two-thirds of the Senate, well over half the House, and the president of the United States are on record as supporting a national law to end insurance discrimination against psychiatric patients. It is truly remarkable that the debate is no longer about "if" we should have such a law, but "when" and in what form. That is an extraordinary accomplishment and change in attitude.

Yes, there is much still to be done. Priority issues include the following:

- **Parity:** The devil will truly be in the details of any national parity law, and we still need to prod a reluctant few legislators into easing their opposition, which is based on stigma rooted in fear and ignorance. Their opposition is aided and abetted by powerful political forces opposed to any such law, mostly for business reasons.

- **Medicare:** Continuing gaps in Medicare coverage—such as the 50 percent copayment limit, the 190-day lifetime reserve, and the absence of a meaningful intermediate nonresidential benefit—must also be addressed.

- **Psychiatric Workforce:** We will need a sustained and focused effort to enhance the supply of psychiatrists nationwide, particularly those willing to serve in remote and underserved inner-city communities.

- **Scope of Practice:** We will be monumentally challenged by economically motivated nonphysician mental health practitioners who seek to obtain a "medical degree" by legislative fiat rather than medical education and supervised residency training and to expand their scope of practice at the risk of patient safety.

- **Managed Care:** We will need to provide support and leadership to individual members struggling with insurance plans whose main purpose is to deny medically necessary care rather than to ensure the provision of optimal biopsychosocial treatment.

- **Research Funding:** The era of easily

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Screening

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take, the theme of this year's NASD is "Alcohol and Health: Where Do You Draw the Line?" It will, for example, provide materials for screening sites on how alcohol intake can be detrimental to the developing fetus, people who take certain medications, and the elderly.

Clifton Schermerhorn, M.D., an associate professor of family practice and psychiatry at Western University of Health Sciences in Pomona, Calif., is an expert on the ways in which alcohol affects the human body. He told *Psychiatric News* that he is concerned about recent publicity touting the benefits of alcohol that landed on the front page of newspapers throughout the country in mid-January under headlines such as "Daily Alcohol Use Cuts Risk of Heart Attack."

Results from the Health Professionals Follow-Up Study, an ongoing project based at the Harvard School of Public Health, found that drinking one or two glasses of wine, beer, or other type of alcohol a day significantly reduces the risk of heart attack.

"These messages can be very harmful to the public," said Schermerhorn. "We live in a world of sound bytes and headlines. The problem is that we see the headline and don't read on."

Schermerhorn pointed out that the study on alcohol intake controlled for the heart only. "What we don't see are the greater numbers of people placed at risk for alcoholism, liver damage, or cancer of the esophagus."

He said that he plans to screen "as many people as possible" for alcohol abuse and dependence on April 10.

Those who register to provide alcohol screening receive a publicity guide with recommendations for publicizing the screening that includes sample press releases and public service announcements, a procedure manual with instructions about how to implement the screening, and a kit of materials with screening forms, a video, educational flyers, and brochures.

Schermerhorn emphasized the unique niche that psychiatrists can fill in the alcohol screening project. "Alcoholism is an emotional and physiological disease, and only psychiatrists are trained to deal with both of these components—this is a disease that must be treated holistically."

Registration for NASD is free and can be completed online at <www.mentalhealthscreening.org/alcohol.htm> or by contacting the National Alcohol Screening Day office at (800) 253-7658. ■

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achieved significant increases in federal research support for mental and addictive disorders is coming to an end. We face great challenges in sustaining the historic high levels of funding we have achieved over the past several years.

• **Public Psychiatry:** Above all else, we will need to work in partnership with federal and state legislators and patient advocates to craft an effective response to the crumbling public mental health infrastructure in an era of major national, state, and local budgetary shortfalls. These are very serious challenges for the next director of DGR and the new leadership of APA.

In closing, I would like to offer my deep appreciation, admiration, and gratitude to every member of the DGR staff. Their dedication to you, our members, and commitment to excellence have made Team DGR the medical association equivalent of Super Bowl and World Series champions. It is the nature of lobbying that many of our successes occur behind the scenes, out of public view. You should know how hard your dedicated and talented DGR staff has worked on your behalf throughout my tenure at APA. You will not find a better team in Washington, D.C.

Many of you know Gene Cassel, our longtime deputy director for regulatory affairs, who will now be acting director of DGR. Gene is well known to our elected leadership and has for many years provided strong staff support to our AMA delegation, as well as expert guidance on regulatory policy impacting psychiatry, and I wish him well. I am confident that with Nick Meyers, Michael Strazzella, Nancy Trenti, and Lizbet Boroughs continuing as your most able federal lobbyists, with dedicated support from Patti Moody; Paula Johnson, Heather Whyte, and Lisa Fields on crucial issues confronting our state associations and district branches; Jason Pray running our remarkably successful startup PAC operation; Julie Abadie coordinating our legislative and regulatory advocacy message; and Tom Graham, Emory Rogers, and Sara Makso providing truly dedicated support, your Team DGR will continue to ensure that psychiatrists are ably represented in Washington, D.C.

Special mention must also be made of the exceptional contributions of Linda Hughes, who for many years has done a great job keeping Team DGR running smoothly. She will now be running the APA Office of Ethics and District Branch/State Association Relations.

Finally, let me offer a heartfelt thanks to you and your dedicated and talented district branch/state association staff who have worked so hard on behalf of your profession and particularly your patients throughout my association with APA. The progress that we have made nationally simply could not have been accomplished without your tireless dedication and generosity.

This has been a remarkable journey together. My very best wishes to you and your families for a healthy, safe, and happy new year. I hope we will stay in touch in the months and years ahead. ■

AMERICAN PROF AGENCY
P4C

"So Now What?"

BY DAVID LIPSIG, M.D.
MATTHEW NORMAN, M.D.

So you have made it through your psychiatry residency and chosen to start a private practice.

You felt that you were well liked and respected by the faculty and other residents in your program. You have a few patients who stayed with you from your residency, and the phone rings a few times in the first week or two. It wasn't the "ringing off the hook," however, that you hoped for, but you figure that the number of calls will increase.

You are now a month into your practice and have gotten some new patients. Then the phone stops ringing! You check your voicemail/answering service and cringe at the familiar voice at the other end saying, "You have no new messages." You tell yourself that new patients don't like to call on the week around a holiday weekend, Mondays, or Fridays.

Another week or two go by. You begin to check your messages obsessively. The perceived response is an almost mocking, "You have no new messages!"

Denial sets in. Perhaps new patients don't like to call during the first two weeks of the month of August? Or maybe on cloudy days? You wait. The phone doesn't ring. Now what do you do?

The first thing to do is to panic. Perhaps you are not as good a psychiatrist as you thought. You should probably rethink your profession and the rest of your life. Of course, this is a joke, and if you didn't realize that, you should go on vacation. Now!

In all seriousness, however, the answer is don't panic. You need to realize that primary care physicians, psychiatrists, and other possible referral sources are perhaps not aware of your new practice. This is a sign that you need to market your practice.

Wait a minute. Marketing is what all those other people in college studied while you were toiling away in organic chemistry. Since you probably never learned marketing techniques in college, medical school, or residency, the next question is how best to do this.

The most important marketing rule in terms of developing new referral sources is "face time." First, don't feel reluctant to let physicians with whom you have worked know that you have opened your practice. You need to stop staring at the phone and make a list of those resources. The list should include present and possible future referral sources. For example, you could stop by a group primary care office. When you go, look professional, shake a lot of hands, and give out your business cards. Emphasize that it is your policy to do everything you can to see new patients within 24 to 48 hours (after all, what else to you have to do at the moment—stare at the phone?). You need to be on the minds of the primary care physician, psychiatrist, or psychologist for you to defeat the mocking banter of "You have no new messages!"

Other ways to increase the amount of face time is to have periodic office receptions. Such receptions provide a reason to contact potential referral sources and give them an opportunity to see where you work. The more they are thinking of you and your practice, the greater chance that they will start referring patients to you.

Believe it or not, a short time later you will hear, "You have new messages." Great! So your efforts were successful. You're done. Time to go out and buy a new convertible roadster.

No. No. No!

An important lesson is not to rest once the phone starts ringing. Even though you are now busy, the phone may not continue to ring at that pace. Private practice ebbs and flows. Therefore, you should view the marketing of your practice as an ongoing process—in fact, a full-time job. There should be no or minimal days spent staring at the phone—those slow days can be used to meet and make new contacts. Get active by going to other receptions, giving presentations, and joining committees in your community. Try to think of other offices you can visit and whom to invite to your next reception (make it inclusive, not exclusive). When you do get referrals, you should thank each referral source individually.

David Lipsig, M.D.

Matthew Norman, M.D.

Remember that building a private practice is like a marathon. You have to prepare adequately. You have to pace yourself. Most importantly, enjoy the race. When your practice is going well, you can look back and ask, "So now what?" ■

Drs. Lipsig and Norman recently established a private group practice in Atlanta after completing their training in general and forensic psychiatry at Emory University.

In Memoriam

The following is a list of APA members whose deaths were reported to APA between October 1, 2002, and December 31, 2002. Deceased members are remembered each year at APA's Business Meeting, held in conjunction with the annual meeting.

Albert Ackerman, M.D.
John Alden, M.D.
Vance T. Alexander, M.D.
Leon L. Altman, M.D.
H. Roberts Bagwell, M.D.
Maudie M. Burns, M.D.
Barbara Louise Calhoun, M.D.
Robert Edwin Cameron, M.D.
Jack Michael Clemente, M.D.
Robert H. Coffer Jr., M.D.
Arlin B. Cooper, M.D.
Verne E. Cressey, M.D.
Robert M. Derman, M.D.
Hayden H. Donahue, M.D.
Ira Michel Frank, M.D.
Vera V. French, M.D.
Edwin M. Fuchs, M.D.
Corazon Banez Guzman, M.D.
Charles Steele Haughton, M.D.
Julius Hoffman, M.D.
James S. Horewitz, M.D.
Robert E. James, M.D.
Millard Jensen, M.D.
Milton Edward Jucovy, M.D.
Irwin G. Kasle, M.D.
C. Frank Knox Jr., M.D.
Joseph W. Lamberti, M.D.
Vincent J. Lamparella, M.D.
Louis Landman, M.D.
Robert E. Le Lievre, M.D.
Andrew R. McDonald, M.D.
James Grier Miller, M.D.
Kurt M. Morbitzer, M.D.
Richard W. Murray, M.D.
Robert E. O'Connor, M.D.
Frances P. Olson, M.D.
Louis Pasternak, M.D.
Jaime Perea, M.D.
Dawn Marie Polk, M.D.
Kurt Conrad Rawitt, M.D.
Joseph E. Reahl, M.D.
Eugene Gayle Roach, M.D.
Richard C. Robertiello, M.D.
Leonor J. Rodriguez, M.D.
John F. Ryan, M.D.
John H. Sayers, M.D.
Girish V. Shah, M.D.
William H. Sisson, M.D.
James C. Skinner, M.D.
Marie T. Lane Snow, M.D.
William E. Sorrel, M.D.
David M. Stockford, M.D.
William C. Strang, M.D.
Joseph D. Sullivan, M.D.
Harold D. Udelman, M.D.
Warren Taylor Vaughan Jr., M.D.
Richard Villarreal, M.D.
Hazel Joan Weinberg, M.D.
Lewis M. Williams, M.D.
Fred T. Zimmerman, M.D.

APA Co-Writes Educational Booklet On Seclusion and Restraint

APA joins with other concerned organizations to educate health care professionals and administrators on how to reduce their use of seclusion and restraint.

BY KEN HAUSMAN

With patient safety issues rapidly gaining prominence on the national health care agenda, APA has teamed up with three other concerned organizations to develop a publication that describes strategies for reducing the use of seclusion and restraint.

The 42-page booklet, titled "Learning From Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health," was created by APA, the American Psychiatric Nurses Association, and National Association of Psychiatric Health Systems, with support from the American Hospital Association's Section for Psychiatric and Substance Abuse Services.

The resource guide is organized as "a compendium of strategies that direct care providers and administrators may want to consider" as they evaluate their facilities' policies and procedures regarding use of restraint and seclusion, according to a press release from the four groups.

The document stresses the crucial need to involve families and consumers in policy planning around this issue and should assist those same groups in understanding clinicians' thought processes as they assess circumstances in which restraint or seclusion might be appropriate.

Material for the publication was compiled from literature reviews, structured interviews with members of the sponsoring organizations, and ideas solicited from other experts in the mental health care field. It includes lists of resources and publications to which professionals and others can turn to get further information on the topics discussed.

Sample checklists and assessment forms are also included in the document.

The release of this publication comes at a time when there is pressure from the regulatory, accreditation, and legislative fronts to minimize use of these often controversial procedures.

"The purpose of this project is to identify a body of high-quality clinical and operation information related to restraint and seclusion that can be recommended to the field," said Charles Riordan, M.D., chair of the APA Committee on Standards and Survey Procedures.

Jane White, R.N., D.N.Sc., executive director of the American Psychiatric Nurses Association, noted that the publication "is full of ideas for creative approaches that both clinical and administrative staff members can take to maintain a culture of safety that will lead to improved patient satisfaction and improved quality of care."

APA has made the publication available at no cost on its Web site at <www.psych.org/clin_res/learningfromeachother.cfm>.■

Dopamine Pathway May Link Schizophrenia, Bipolar Disorder

A common molecular pathway may lead to variations in dopamine dysfunction that manifests as either schizophrenia or bipolar disorder, tying the two disorders together as "chemical cousins."

BY JIM ROSACK

Researchers have long focused on dopamine dysfunction as a likely source of mental illness, in particular implicating abnormalities in the dopamine system in schizophrenia, bipolar disorder, and attention-deficit/hyperactivity disorder. A new report now indicates that in schizophrenia and bipolar disorder, dopamine itself may not be the culprit, but rather other molecular systems in the brain that control dopamine transmission.

In a report published in the December 13, 2002, online edition of the *Proceedings of the National Academies of Science*, researchers from the University of Maryland, Pennsylvania State College of Medicine, and Yale University say that an increase in the activity of a particular regulatory protein in the brain may be the root of both disorders. Neuronal calcium sensor-1 (NCS-1), according to the report, is abnormally elevated in the dorsolateral prefrontal cortex of postmortem samples from patients with schizophrenia or bipolar disorder.

Recent research has suggested that dopamine receptor-interacting proteins (DRIPs) may play a role in modifying and expanding the functionality of dopamine receptors. In addition, using tissue samples from the Stanley Foundation Neuropathology Consortium, the Maryland-led team had previously shown that levels of a particular DRIP, calcyon, is elevated to nearly twice the normal levels in the prefrontal cortices of patients with schizophrenia. Calcyon has been implicated in the regulation of dopamine-D1 receptors.

Rigorous Methods

In the current study, the Maryland team hypothesized that NCS-1, also a DRIP, could also be involved in dopamine dysregulation. NCS-1 has been shown to be present in cells throughout the brain and is involved in modulating the sensitivity of the dopamine-D2 receptor. When levels of NCS-1 increase, the receptor becomes less sensitive to dopamine, and lower levels of NCS-1 allow the receptor to become more sensitive to the neurotransmitter.

The researchers were careful to conduct the study using rigorous methodology in an effort to eliminate confounding variables. Using postmortem tissue samples, once again from the Stanley Foundation, the study analyzed levels of NCS-1 in the dorsolateral prefrontal cortex of 60 individuals, comparing 15 patients in each of three diagnostic groups: schizophrenia, major depression, and bipolar disorder, with 15 control subjects with no history of psychiatric or neurological disorders. Each of the 60 samples was tested in triplicate, and an average level of NCS-1 measured across the three tests was used for analysis.

The diagnostic groups were matched according to age, race, gender, anatomical location of the actual tissue sample, average time of tissue storage since death, and pH of the tissue sample. All of the analyses of tissue samples was completed in a blind manner. Because it has been shown that treatment with haloperidol for periods of at least three months can cause changes in both D1 and D2 receptors, samples were also analyzed from five drug-naïve and five haloperidol-treated rhesus monkeys to determine whether levels of NCS-1 are drug dependent.

Pattern Emerges

The team found that the dorsolateral prefrontal cortices of patients with schizophrenia and patients with bipolar disorder had significantly elevated levels of NCS-1—on average 50 percent higher than the normal, control individuals. No significant difference was detected in levels of NCS-1 between the control individuals and patients with major depression.

In addition, no significant difference was found when the researchers compared levels of NCS-1 in patients who had schizophrenia or bipolar disorder and had been taking antipsychotic medications for prolonged periods at death and patients in the same sample groups who were drug free. The comparison between the haloperidol-exposed and drug-free rhesus monkeys also failed to show any statistically significant difference in levels of NCS-1 in the dorsolateral prefrontal cortex.

The consequences of increased levels of NCS-1 are intriguing, though not well understood. "Based on [D2 receptor] involvement in inhibition of dorsolateral prefrontal cortex activity," the researchers concluded, "the observed NCS-1 up-regulation might be expected to result in decreased activation of the dorsolateral prefrontal cortex in schizophrenia and bipolar patients. Furthermore, this could occur without any detectable change in the level of [D2 receptors]."

It is also possible, they added, that increases in NCS-1 could affect signal processing by promoting particular potassium currents in neuronal cells, which would indirectly affect calcium regulation, altering neurotransmission.

The research was funded by the National Institute of Mental Health Conte Center for Research in Mental Disorders and the Essel Foundation.

The study, "Up-Regulation of Neuronal Calcium Sensor-1 (NCS-1) in the Prefrontal Cortex of Schizophrenic and Bipolar Patients," is posted on the Web at <www.pnas.org/cgi/doi/10.1073/pnas.232693499>. ■

It's Back to the Future For Ulcers and Anxiety

The French adage "The more things change, the more they stay the same" may apply to peptic ulcers. Anxiety was once considered a cause of these ulcers—and now it is again.

BY JOAN AREHART-TREICHEL

A few years ago, it was all the rage to blame ulcers of the stomach or duodenum on stress or anxiety. Then the bacterium *Helicobacter pylori* was fingered as a cause for these peptic ulcers, and a psychological explanation for them fell into disrepute.

However, while nearly all peptic ulcer patients have *H. pylori*, only a small number of people with the bacterium get peptic ulcers, suggesting that some other factor, maybe psychological, might be necessary for *H. pylori* to cause ulcers. A new study suggests that this other factor might be chronic anxiety. The study has found not only a statistically significant link between chronic anxiety and peptic ulcers in a large population sample, but a connection between the amount of worrying people do and their risk of peptic ulcers.

The study was conducted by Renee Goodwin, Ph.D., an assistant professor of epidemiology at Columbia University, and Murray Stein, M.D., a professor of psychiatry at the University of California at San Diego. The study was reported in the November/December *Psychosomatic Medicine*.

From 1990 to 1992 a large, nationally representative survey called the National Comorbidity Survey was undertaken. It was based on a sample of some 8,000 people 15 to 24 years of age. The 8,000 individuals reported whether they were experiencing one or more mental disorders, including generalized anxiety disorder, or whether they were experiencing one or more physical health problems, including a peptic ulcer. Goodwin and Stein decided to use data from this survey to explore a possible relationship between generalized anxiety disorder and peptic ulcer disease.

After taking sociodemographic differences and comorbid mental disorders into consideration, the researchers found a statistically significant link between the presence of generalized anxiety disorder and the presence of a peptic ulcer. Persons with generalized anxiety disorder had a 2.2 greater chance of having a peptic ulcer than persons without the disorder.

The investigators also found a dose-response relationship between generalized anxiety disorder and peptic ulcer disease—in other words, with each anxiety symptom reported, the individual had a 20 percent greater chance of having an ulcer. The anxiety symptoms included restlessness, being irritable, being tense, being keyed up, trembling, or having trouble concentrating.

Moreover, the researchers attempted to see whether having a specific physical health problem—say, asthma, arthritis, diabetes, high blood pressure, or kidney disease—increased the likelihood of having generalized anxiety disorder. After taking sociodemographic characteristics into consideration, they found that the only physical health problem that increased the likelihood was a peptic ulcer.

If chronic worrying does help precipitate peptic ulcers, how does it do it? It might shift immune reactions to *H. pylori*, the researchers proposed. And if chronic worrying helps trigger peptic ulcers, treatment for anxiety, such as antidepressants, might help counter peptic ulcers. Antidepressants have led to improvement among patients with other types of gastrointestinal problems, such as irritable bowel syndrome *(Psychiatric News*, July 20, 2001). In fact, as the researchers suggested in their study report, peptic ulcers might be effectively treated by combining antidepressants with *H. pylori* medications.

Psychiatric News asked Goodwin whether she and Stein will be conducting any more studies on anxiety and peptic ulcers. She replied: "We would like to investigate the relationship between generalized anxiety disorder and ulcers using prospective, longitudinal, epidemiologic data, including data on physiologic measures of ulcer." She and Stein might also look "at whether treatment of generalized anxiety disorder is associated with improvement in ulcer outcome."

The study by Goodwin and Stein also raises the intriguing possibility that chronic anxiety may not be the only psychological state capable of triggering a peptic ulcer. After adjusting for demographic differences and current psychiatric comorbidity, the researchers found a statistically significant link between not just generalized anxiety disorder and peptic ulcer, but between specific phobia and peptic ulcer, and between bipolar disorder and peptic ulcer.

"It could be that generalized anxiety disorder, phobia, and bipolar disorder share some common underlying feature that links each of them with ulcer," Goodwin told *Psychiatric News*, "or there may be separate mechanisms for each of these associations."

An abstract of the study, "Generalized Anxiety Disorder and Peptic Ulcer Disease Among Adults in the United States," is posted on the Web at <www.psychosomaticmedicine.org/cgi/content/abstract/64/6/862>. ■

Association News

Applications Invited For Elsa Barton Scholarship

Applications are now available for the 2003 Elsa Barton Scholarship of the American Psychiatric Association Alliance.

The purpose of the scholarship is to provide financial assistance for the postsecondary educational needs of an immediate family member of a deceased, disabled, or impaired physician. The scholarship may be applied to tuition, books, computers, and other related educational expenses at a college, university, or vocational institution in which the student is enrolled or will be attending. The scholarship is awarded to the spouse, partner, or young adult dependent, not to the physician. Completed applications must be received no later than April 1.

Donations are tax deductible. Checks may be mailed to Angela Poblocki, Executive Secretary, APAA, P.O. Box 285, North Boston, N.Y. 14110. Applications and additional information are also available from Poblocki at this address or at <www.APAAlliance.org>. ■

Cocaine Appears to Damage Brain's Dopamine Neurons

Cocaine affects the same brain cells that are responsible for the high that users get from the drug.

BY DAVID MILNE

Analysis of postmortem brain tissue has provided the most comprehensive evidence that chronic cocaine use reduces striatal levels of vesicular monoamine transporter protein (VMAT2) and results in dopamine neuronal changes related to disordered mood.

"This is the clearest evidence to date that cocaine dependency results in deleterious changes in dopamine neurons," Karley Little, M.D., chief of the Ann Arbor VA Medical Center's Affective Neuropharmacology Laboratory and an associate professor of psychiatry at the University of Michigan Medical School, told *Psychiatric News*.

The study, revealing differences in dopamine neurons between postmortem brain tissue from cocaine users and controls, appeared in the January issue of the *American Journal of Psychiatry*. Little and colleagues David Krolewski, M.S., Lian Zhang, Ph.D., and Bader Cassin, M.D., assessed the integrity of the dopamine system in brain tissue from 35 known cocaine users and 35 nonusers matched for age, sex, race, and cause of death. Using tissue from the striatum, an area of the brain with the highest concentration of dopamine neurons, they measured the level of VMAT2, a protein that pumps dopamine molecules into storage vesicles; VMAT2's binding availability to a selective radiotracer molecule, another assessment of VMAT2 presence and activity; and the overall dopamine level to find how much was available at the time of death. They found that all three levels were lower in cocaine users than in nonusers. And levels tended to be lowest in cocaine users who were diagnosed as having cocaine-induced mood disorders at the time of their deaths.

It has long been known that immediately after cocaine exposure, synaptic dopamine increases, an event believed to be critical in causing the pleasurable experience associated with cocaine intake. The present study illuminates the molecular mechanisms responsible for the withdrawal symptoms and sustained depression that some cocaine users experience after chronic use. Other researchers have found that those individuals who not only experience pleasure from cocaine use, but also are "punished" by its withdrawal, by dysthymic and suicidal feelings, as well as persistent depression, are those who are hard to treat and whose addiction is most disruptive.

Traditionally, cocaine use has not been associated with the intense physical dependence that is seen with alcohol and narcotics. But the clinical literature does indicate that cocaine users have withdrawal symptoms—which vary a lot between individuals, from mild to intense. About a third feel markedly depressed, listless, anxious, and uncomfortable. It has become clear that people who have those symptoms are likely to become more dependent on the drug and find it harder to quit.

"Our data provide a very good biochemical basis for cocaine withdrawal symptoms. The existing literature shows that a depressed cocaine user is going to have more problems maintaining family and work, have a harder time quitting, is more likely to drop out of treatment, and is more likely to commit suicide," Little said.

Vesicular monoamine transporter (VMAT) collects the neurotransmitter into the vesicle after it is synthesized or been returned to the cell from the synapse. Variations in its level are a measure of vesicular stores of neurotransmitter, but also of total number of neuronal axons.

"Thus the present finding may mean that the neuron is trying to adapt and down-regulate how much dopamine it releases, or it may mean that there is some damage or loss of neurons," Little said. "Our findings are somewhat controversial because no one has been able to show that the VMAT is down-regulated by drugs, but neither has anyone found that cocaine kills nerve cells. At this point we don't quite know how to interpret this decrease in VMAT function.

"What we need to do now is to count the dopamine neurons and axons in our remaining samples, which is a big undertaking. If we find they are not decreased, then it will mean we are dealing with an unprecedented down-regulation of the VMAT . . . . And if they are diminished, then we are dealing with unprecedented neuronal loss. Either way, it is going to be an interesting outcome. If the change is permanent, it is quite a problem, and if it is reversible, then we must find out the mechanism by which it can be reversed."

This is the latest in a series of experiments begun in 1993 by Little and colleagues, who initially found that chronic cocaine use increases the synaptic dopamine transporter (DAT), the actual molecule to which cocaine binds and inhibits. The reuptake activity of this molecule represents the other half of the equation that controls how much dopamine exists in the synapse. After releasing neurotransmitter, neurons quickly suck it back into the cell that released it, thus sharpening the communicative process and conserving neurotransmitter for continued use.

"This is the clearest evidence to date that cocaine dependency results in deleterious changes in dopamine neurons."

By helping lessen synaptic levels of dopamine, up-regulation of synaptic dopamine transporter may be helpful in some individuals by helping lessen synaptic levels of dopamine when cocaine is present. But when cocaine disappears, the increase in uptake means there will be even less dopamine in the synapse. In conjunction with diminished dopamine release from vesicles, this may lead to decreased response to normal rewards. Thus, normal rewards become less significant, and cocaine less effective, so the dosage must be increased. Thus, a classic cycle of tolerance—dose escalation—and resetting of reward levels may develop, a process sometimes called allostasis, in contrast to homeostasis.

The drug amantadine is mildly helpful in reducing cocaine withdrawal symptoms and keeping cocaine addicts in treatment. It is especially useful for depressed cocaine users, in contrast to the SSRIs, which don't seem very effective. This fact has suggested that cocaine-induced mood disorders have a more dopaminergic than serotoninergic basis. Little has developed a cell culture model of the up-regulation of DAT by cocaine (*Molecular Pharmacology* 61:436-445, 2002). In this model, he has found that amantadine has a reverse effect compared with cocaine, suggesting how it might mitigate the effects of chronic cocaine exposure on dopamine transport. Using this model system, it may become possible to develop drugs that are better than amantadine.

The vulnerable nature of dopamine neurons is important in understanding the moods and actions of normal adults as they age and lose dopamine neurons naturally. Considerable evidence suggests that uncontained dopamine may be mildly toxic over time.

These studies were funded by NIDA and a VA Merit Award.

The study, "Loss of Striatal Vesicular Monoamine Transporter Protein (VMAT2) in Human Cocaine Users," is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/160/1/47?>. ■

Colicky Babies Seriously Stress Moms, But the Anxiety Is Short-Lived

The good news for mothers of colicky babies is that the crying will probably be over by three months and that the mothers will survive the experience without psychiatric consequences.

BY JOAN AREHART-TREICHEL

A baby with colic is one of a new mother's toughest challenges. Yet there may be some good news for those new mothers who have one: The excessive, inconsolable, maddening crying will probably be over by three months of age, and the mothers will probably survive the experience without psychological damage.

So, at least, suggests a study conducted by Tammy Clifford, Ph.D., director of epidemiology at the CHEO Research Institute in Ottawa, Ontario, Canada; Fabian Gorodzinsky, M.D., an assistant professor of pediatrics at the University of Western Ontario; and coworkers. The study was published in the December *Archives of Pediatrics and Adolescent Medicine.*

Colic is a relatively common condition of early infancy, characterized by crying, fussiness, and irritability at least three hours a day and occurring more than three days in any one week, even though an infant is healthy and well fed. Although studies have suggested that colic usually ends by three months of age, with little lasting effect on either infant or mother, these studies have focused on clinically referred cases and have been retrospective in nature. So Clifford and her colleagues decided to undertake a prospective study based on a general population sample to see whether they would get the same finding.

They recruited some 550 women who gave birth in London, Ontario, in 1999 to participate in their study. Subjects were given four questionnaires to fill out. The first questionnaire, given one week after mother and newborn were discharged from the hospital, used standardized instruments to identify and measure maternal anxiety and depression. The second and third questionnaires, given at six weeks and at three months after hospital discharge, consisted of standardized instruments designed to identify and measure infants' crying behaviors. The fourth questionnaire, given at six months after hospital discharge, used standardized instruments to identify and measure maternal anxiety and depression.

Clifford and her coworkers first used the data to determine how prevalent infant colic was at six weeks after discharge and again at three months after discharge. They learned that whereas 131 infants had had colic at six weeks, only 18 still had it at three months, indicating that 86 percent of cases had remitted by three months. This finding was essentially what researchers have found in retrospective studies, further bolstering the case that most cases of colic will cease around three months of age.

Clifford and her colleagues then used the data to determine whether their subjects' mental states had been influenced by having a colicky baby. They found that mothers who had not had a colicky infant experienced, on average, less anxiety and depression at six months after hospital discharge than they had experienced one week after discharge. They also found that mothers who had had a colicky infant experienced, on average, less anxiety and depression at six months after hospital discharge than they had experienced one week after discharge, but the reduction was not as great as for the former group. However, the difference in anxiety and depression reduction between the two groups was not statistically significant.

So, having a colicky baby at six weeks after discharge may make mothers a little more anxious and depressed than they would have been if they had had a noncolicky baby at six weeks after discharge, but not all that much more so, Clifford and her team concluded.

This study, however, did not specifically address the mental health of those 18 mothers who had the misfortune of having a colicky baby not just six weeks after discharge, but still at three months after discharge. It is quite possible that the mental health of these women suffered a lot more than that of the women exposed to colic for a shorter period.

Nor did the investigation address the mental health of the 17 mothers whose infants did not become colicky until three months after discharge. In an accompanying editorial, Ronald Barr, M.D., a McGill University colic authority, proposed that it may very well be those infants who become colicky only at three months, and not earlier, who have difficult temperaments.

An abstract of the study, "Sequelae of Infant Colic: Evidence of Transient Infant Distress and Absence of Lasting Effects on Maternal Mental Health," is posted on the Web at <http://archpedi.ama-assn.org>. ■

LILLY ZYPREXA
P4C

Punishment Beliefs Tied to Depression in Those With HIV

People with HIV infection sometimes have psychological issues that need to be treated. A belief that their HIV is a form of punishment is one such factor with a strong depression link.

BY KEN HAUSMAN

Despite all the scientific evidence about how the AIDS virus is transmitted and devastates its victims' immune systems, some people infected with HIV believe it somehow is a form of punishment. And data from a recent study strongly suggest that people who hold this belief are more likely to suffer from depression and have a poorer outcome and quality of life.

As a result of this finding, psychiatrists and mental health professionals may be of far more value to HIV-infected individuals if they focus therapy on a person's punishment-related HIV beliefs instead of the more obvious, though severe, stressful life events that these patients usually have endured, the researchers suggested.

Along with the stigma-driven belief that their illness is a form of punishment, three other factors—pessimism about the benefits of HIV treatment, poor problem-solving skills, and inadequate social supports—are linked with depression in many HIV-positive individuals, according to a study by Steven Safren, M.D., of Massachusetts General Hospital and colleagues in Boston and Vancouver, Canada.

The researchers found a strong relationship between these same psychological factors and measures of quality of life and self-esteem.

These factors are especially critical in HIV-infected individuals taking the powerful combination of AIDS-fighting drugs, because they can compromise adherence to the complex medication regimen required for the drugs to be effective.

In a study reported in the December 2002 issue of *Psychosomatics*, Safren's team evaluated 76 men and eight women who had HIV infection and were taking or about to begin taking the combination of antiretroviral medications known as highly active antiretroviral therapy (HAART). Those who were already taking the medications were eligible if they were about to change their medication regimen "or were having subjective difficulties with their current regimen." The large number of medications and the need to take them at precise times throughout the day—and night—make HAART itself a stressful undertaking, the researchers noted.

Participants were aged 23 to 68 (the mean age was 41.5) and were ethnically diverse; 80 percent were gay. Subjects were recruited through newspaper ads and posters in a primary care clinic in which a substantial number of HIV-infected individuals seek care.

Now that the length of survival has increased substantially for HIV-infected people, they and their therapists are able to focus on issues of quality of life, self-esteem, and adaptive coping behaviors.

With almost all people with HIV infection having experienced considerable life stressors, especially those on HAART, the researchers decided to assess the impact of several cognitive and behavioral variables on the psychological well-being of individuals on this type of therapy.

The researchers used a variety of assessment measures including the Beck Depression Inventory, Quality of Life Inventory, Life Experience Survey, Social Support Questionnaire, and the coping-style measurement COPES.

A key finding of the study, Safren and his colleagues noted, is that "punishment beliefs about HIV infection had a significant negative association with self-esteem, a significant positive association with depression, and a nonsignificant negative association with quality of life."

Their analysis indicated that other relationships were in the expected directions; that is, social-support satisfaction was positively associated with quality of life and self-esteem and negatively associated with depression, while maladaptive coping was negatively associated with quality of life and self-esteem and positively associated with depression.

"Stressful life events initially accounted for a significant portion of the variance associated with depression and perceived quality of life," Safren and his team pointed out. "However, once additional variables pertaining to perceived social support, adaptive coping, and punishment beliefs about HIV were included in the model, the contribution of negative life events lost its significance."

In light of these findings, the researchers concluded that "in patients taking HAART, psychosocial variables that are amenable to intervention efforts may be better predictors of psychological well-being than stressful life events per se."

Thus, they pointed out, clinicians "may offer substantially larger benefit to quality of life" by focusing on critical well-being factors such as social support, development of positive coping strategies, and punishment-related beliefs about HIV disease.

"Psychoeducation or referral to cognitive-behavioral therapy, which actively targets adaptive coping strategies," could be effective in achieving these therapy goals, they added. ■

med check

COMPILED BY JIM ROSACK

Regulatory Briefs

• The Food and Drug Administration (FDA) on January 3 approved fluoxetine (Prozac, Eli Lilly and Co.) for the treatment of children and adolescents aged 7 to 17 for major depressive disorder and obsessive-compulsive disorder (OCD). This is the first approval of an SSRI for depression in the child and adolescent population. The approval was based on two placebo-controlled clinical trials in children and adolescents being treated for depression as outpatients. The OCD indication was also based on two clinical trials. The long-awaited approval legitimizes many years of use of fluoxetine in pediatric patients as the most common drug prescribed for depression in patients under 18 years of age.

Reported common side effects associated with use of fluoxetine in pediatric populations are similar to those reported in adults, including nausea, fatigue, nervousness, dizziness, and difficulty concentrating. Lilly agreed to an FDA request to conduct a Phase 4 postmarketing study to evaluate the long-term effects of the drug on growth after one trial noted a slight (about 1 cm and 1 kg) decrease in average height and weight of children treated with fluoxetine. An FDA Talk Paper on the topic is posted on the Web at <www.fda.gov/bbs/topics/answers/2003/ans01187.html>.

• The FDA also tentatively approved in mid-January generic forms for both nefazodone (Serzone, Bristol-Myers Squibb) and mirtazapine (Remeron, Organon.) Both generic approvals stem from patent challenges to the two brand names from generic manufacturers. Serzone is protected by two patents, the first expiring in September 2003 and the second expiring in October 2012. Remeron is protected by a single patent, a rare situation in an environment where most drug manufacturers gain multiple patents for each product in an attempt to maintain protection for longer periods. Remeron's single patent expires in 2017. Courts would have to rule the existing patents invalid for final FDA approval to be granted. Neither company could be reached for comment on the patent challenges.

• In response to the filing of an abbreviated New Drug Application with the FDA, Shire Pharmaceuticals vowed to fight an attempt by the generic manufacturer to gain marketing approval for a generic form of Adderall XR (mixed amphetamine salts, extended release). In a press release dated January 9, Shire said that the extended-release formulation will remain under valid patent protection until at least mid-2005. If all the company's multiple patents were to be upheld during patent-challenge litigation, the brand would be protected until 2018.

• GlaxoSmithKline has won a significant victory in its legal fight to preserve patent protection for Paxil. A U.S. District Court ruling upheld the validity of at least one of four contested patents for the SSRI, preserving patent protection until 2006. Court hearings on the patent expiring in 2006 were scheduled for mid-February. Apotex, a generic drug manufacturer, had sought the court's relief in contesting the validity of the patents in 1998, only five years after the drug's launch in the United States. Of the remaining three contested patents, the court decided in favor of Apotex on one patent, ruling that the patent was invalid. However, the court split on the remaining two patents, holding some claims within those patents valid while striking other specific claims.

Research Briefs

• Risperidone (Risperdal, Janssen) appears to be effective in treating global psychotic symptoms associated with posttraumatic stress disorder. In a five-week, prospective, randomized, double-blind, placebo-controlled trial, patients who received risperidone in addition to other common medications such as SSRIs showed a significantly greater reduction in psychotic symptoms as measured by Positive and Negative Syndrome Scale (PANSS) total scores. Ratings using the Clinician-Administered PTSD Scale (CAPS) also declined significantly; however, no statistically significant difference was seen between risperidone and placebo until the fifth week (end point) of the study. At week five, CAPS subscale scores for core re-experiencing symptoms were significantly more improved for patients taking risperidone than placebo.
(Int Clin Psychopharmacol 2003; 18:1-8)

• Prazosin (Minipress, Pfizer), a centrally acting A_1 adrenergic antagonist used as an antihypertensive, may be effective in reducing nightmares and other sleep disturbances associated with PTSD. In a brief report of data from a 20-week double-blind crossover study, researchers found that prazosin was superior to placebo in two outcome measures on the CAPS: subscores on the recurrent distressing dreams item and the difficulty falling/staying asleep item. In addition, the change in overall PTSD severity, as measured with the Clinical Global Impressions scale (CGI), was also statistically more improved with prazosin than placebo.
(*Am J Psychiatry* 2003; 160: 371-373*)*

• Use of so-called "atypical neuroleptics"—more recently and perhaps more appropriately termed dopamine/serotonin modulators—has increased rapidly in the last several years, largely for symptoms other than psychosis. A new review reports on recent data on the use of the drugs to treat depression and mania, as well as other mood disorders. In addition, the review noted, "atypical antipsychotics are as effective as typical antipsychotics, but are safer and more efficacious than mood stabilizer monotherapy in the treatment of mania."
(Curr Opin Psychiatry 2003; 16:23-27)

• Divalproex (Depakote, Abbott), when combined with olanzapine (Zyprexa, Lilly) or risperidone, contributes to earlier improvements in a range of psychotic symptoms among acutely hospitalized patients with schizophrenia, according to a new study. In a double-blind trial, 249 patients were randomly assigned to receive either olanzapine monotherapy, risperidone monotherapy, divalproex plus olanzapine, or divalproex plus risperidone for 28 days. Improvements were seen in all groups at all time points; however, combination therapy was significantly better as early as day 3 for PANSS total score, Brief Psychiatric Rating Scale (BPRS) total score, and their subscales.
(Neuropsychopharmacol 2003; 28:182-192)

• The full report of the International Suicide Prevention Trial (InterSePT), which the FDA used to validate a new indication for clozapine (Clozaril, Novartis) *(Psychiatric News,* December 6, 2002) has been released. Olanzapine was compared with clozapine in 908 patients who had schizophrenia or schizoaffective disorder and were considered to be at high risk for suicide. Suicidal behaviors were found to be significantly less frequent in patients treated with clozapine compared with those treated with olanzapine.
(Arch Gen Psychiatry 2003; 60:82-91)

• Paroxetine (Paxil, GlaxoSmithKline) and clomipramine (Anafranil, Mallinkrodt) appear to be equally beneficial in treating adolescents with severe major depression. A new study aimed to examine the "serotonin hypothesis"—the idea that SSRIs are more effective than tricyclics for adolescent depression because adolescent depression is largely modulated by serotonin and not norepinephrine. The randomized trial compared the two drugs in 121 patients, with 58 receiving clomipramine and 63 receiving paroxetine. Both agents had similar efficacy, measured on the Montgomery-Asberg Depression Rating Scale (MADRS) and CGI scales. Side effects were significantly more frequent with clomipramine than paroxetine.
(J Am Acad Adol Child Psychiatry 2003; 42:22-29)

• A German study found that naltrexone (Revia, Barr Labs) combined with acamprosate—which the FDA deemed unapprovable last fall—provides the best outcome regarding delaying the time to first drink and time to relapse in patients with alcoholism. Subjects had significantly lower rates on both measures than did either medication alone, and all three therapies were significantly better than placebo. Comparing the two medications used as monotherapy, naltrexone showed a tendency toward better rates on both measures than did acamprosate.
(Arch Gen Psychiatry 2003; 60:92-99)

Industry Briefs

• AstraZeneca announced January 2 that it had submitted a Supplemental New Drug Application to the FDA to market Seroquel (quetiapine) for the treatment of acute mania associated with bipolar disorder. Based on three clinical trials, the company is seeking approval to market the drug as both monotherapy and adjunctive therapy with a mood stabilizer.

• Bristol-Myers Squibb announced last month that it had reached agreements that would settle antitrust litigation concerning BuSpar (buspirone). The $535 million settlement will resolve claims that the company had taken allegedly illegal actions in an effort to protect patents and other intellectual property for the drug, which was developed by BMS. While the company did not admit wrongdoing, a press release said, "It would be prudent to enter into settlements to put the uncertainty and risk of this litigation behind the company." ■

clinical & research news

Risk-Taking Behavior Linked to Religiosity, Researcher Suggests

Women tend to be more religious than men throughout the world, a sociologist reports. Could it be because women are usually less willing to take risks than men are? The sociologist thinks so.

BY JOAN AREHART-TREICHEL

Women are one-and-a-half times more likely to be religious than men are in Japan. The same is true for women in Bulgaria—and pretty much the same for women in Russia, Venezuela, and Albania.

In fact, in 49 countries throughout the world women are more religious than men, and with the exception of only one case—Brazil—the differences are significant or highly significant statistically.

These findings come from Rodney Stark, Ph.D., a University of Washington professor of sociology and comparative religion.

"The gender differences hold up everywhere, even in religions that are very male centered, such as Orthodox Judaism," Stark said in a press release from the University of Washington in December. "This is not some fragile finding, and the fact that it shows up in so many cultures says something."

But what does it say? Stark has a hunch that men tend to be less religious than women because they are more likely to engage in risk-taking behaviors. In other words, their willingness to take chances with a displeased deity might be comparable to their willingness to take chances on killing themselves or others or on being jailed.

Stark's findings stem from his scrutiny of data collected by the World Values Surveys. These surveys were planned by an international committee of social scientists, translated into local languages, and conducted by local polling organizations.

The question on the survey regarding religiousness was, "Whether you go to church or not, would you say that you are a religious person?" In every instance, a higher percentage of women than men answered yes to this question, and in every country but Brazil the differences were statistically significant. Specifically, the rates of women to men who said they were religious ranged from 1.06 for Poland to 1.69 for Estonia, with the ratios of the other countries falling in between.

Stark published his findings in the September issue of the *Journal for the Scientific Study of Religion.*

A summary of the paper, "Physiology and Faith: Addressing the 'Universal' Gender Difference in Religious Commitment," is posted on the Web at <http://las.alfred.edu/~soc/SSSR/JSSR.htm>. ■

Alzheimer's Drugs May Offer Psychiatric Benefits

Cholinesterase inhibitors may provide more benefits than many think, not only helping Alzheimer's patients retain their memories, but in neuropsychiatric and functional outcomes as well.

BY JIM ROSACK

Cholinesterase inhibitors, long considered the primary treatment for the cognitive symptoms of Alzheimer's disease, may also improve neuropsychiatric and functional outcomes, according to new research. Researchers believe these improvements may translate into tangible increases in quality of life, including a delay in institutionalization, and help to ease caregiver burden.

In a systematic review and meta-analysis of clinical trials involving cholinesterase inhibitors, Kristine Yaffe, M.D., an assistant professor in residence of psychiatry at the University of California at San Francisco and the San Francisco Veterans Affairs Medical Center, and her colleagues collected data from 29 clinical trials involving the drugs. They focused on those that evaluated not only cognitive decline, but also some aspect of neuropsychiatric or functional outcomes. Of the 29 trials, 16 included measures of patients' neuropsychiatric symptoms, while 18 included data on functional outcomes. The study, funded by the U.S. Public Health Service, was published in the January 8 issue of the *Journal of the American Medical Association*.

Previous research has shown that the vast majority of Alzheimer's patients exhibit at least some neuropsychiatric symptoms as their disease progresses. As many as 80 percent of patients can be expected to experience hallucinations, paranoia, agitation, or affective disturbances during the course of their illness.

While functional impairment is an integral part of the progression of the disease, treatment research has traditionally focused on reducing the rate of cognitive decline in Alzheimer's patients, and clinical treatment has been focused on the use of cholinesterase inhibitors to achieve this therapeutic goal.

Yaffe and her colleagues searched MEDLINE, Dissertation Abstracts On-Line, PSYCHINFO, BIOSIS, PubMed, and the Cochrane Controlled Trials Register for any clinical trials using cholinesterase inhibitors in the treatment of dementia or, more specifically, Alzheimer's. For their meta-analysis, they included only trials that were randomized, double blind, and placebo controlled with either a parallel or crossover design.

Trials had to include at least one month of treatment with one of the following cholinesterase inhibitors: donepezil (Aricept), galantamine (Reminyl), rivastigmine (Exelon), and tacrine (Cognex). In addition, the researchers looked at trials using four cholinesterase inhibitors not approved for marketing in the United States, but are either investigational or available in other countries: eptastigmine, metrifonate, physostigmine, and velnacrine.

Neuropsychiatric outcomes were measured using the noncognitive portion of the Alzheimer Disease Assessment Scale (ADAS-noncog) or the Neuropsychiatric Inventory, and functional outcomes were measured on a validated assessment of basic activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

Of the 16 trials assessing neuropsychiatric symptoms, 14 indicated that patients who received cholinesterase inhibitors benefited from them, seeing a reduction in their symptoms. Two trials indicated no benefit from use of the medications versus placebo. In the meta-analysis of all 16 trials, patients receiving cholinesterase inhibitors saw a small but statistically significant improvement over placebo.

As for the 14 trials assessing functional outcomes, summary meta-analysis of those trials assessing ADLs (such as feeding and dressing) indicated that patients who received cholinesterase inhibitors had statistically significant improvement versus patients taking placebo. For the 13 trials that included IADL outcomes, patients taking a cholinesterase inhibitor improved significantly more compared with those taking placebo. The ADL and IADL improvements were characterized by Yaffe and her co-authors as "small but statistically significant."

The researchers concluded that their "results support the hypothesis that [cholinesterase inhibitors] have a modest beneficial role in treating neuropsychiatric symptoms and reducing functional impairment in patients [who have] mild to moderate Alzheimer's and who are living in the community."

Yaffe and her colleagues also noted that "each of the [drugs] had similar beneficial effects."

The authors called for more research into functional and neuropsychiatric outcomes in patients with Alzheimer's who are taking cholinesterase inhibitors. "Exploring these issues will possibly broaden treatment for Alzheimer's, an illness with growing importance to public health."

"Efficacy of Cholinesterase Inhibitors in the Treatment of Neuropsychiatric Symptoms and Functional Impairment in Alzheimer Disease" is posted on the Web at <http://jama.ama-assn.org/issues/v289n2/abs/jma20041.html>. ■

Antisocial Behavior Contagious For Some Married Couples

Perhaps the expression "partners in crime" can be taken literally. When one spouse engages in antisocial behavior, the other may well do so as well, a new study shows.

BY JOAN AREHART-TREICHEL

As any crime buff knows, Bonnie and Clyde were infamous American criminals back in the 1930s, operating as a husband-and-wife team, although they were not married.

However, there may be some "Bonnie and Clydes" running around today as well. The reason? When one spouse engages in antisocial behavior, the other has a good chance of doing so as well, a new study suggests.

A lot of research has been conducted, of course, on the familial transmission of antisocial behavior. Very few studies, however, have looked to see whether antisocial behavior might also be transferred from one spouse to another, or at least be a kind of behavior in which they both engage. So G. Gaulbaud du Fort, M.D., Ph.D., a psychiatric epidemiologist at the Sir Mortimer B. Davis-Jewish General Hospital in Montreal, Canada, and his colleagues decided to try to answer the question.

Their study included 519 pairs of spouses—that is, 1,038 subjects—randomly selected from a large, previously conducted general population survey. They used the Diagnostic Interview Schedule to determine how many of these 1,038 subjects engaged in antisocial behavior. Finally they used these findings to see whether those persons who engaged in antisocial behavior also had spouses who did so.

The answer was yes in some 20 percent of the cases, they reported in the November *Psychological Medicine*. "Our finding of a strong similarity between spouses for adult antisocial behavior has significant implications for both clinicians and researchers," they wrote.

However, when they looked to see whether those subjects who had engaged in conduct disorder as children also had spouses who had done so, they found only a modest association—about 4 percent. What's more, the spousal similarity for adult antisocial behavior was independent of the spousal similarity for conduct disorder, they discovered.

These findings, they believe, suggest that adult antisocial behavior should be considered a distinct diagnostic entity from child conduct disorder.

An abstract of the study, "Spouse Similarity for Antisocial Behavior in the General Population," can be accessed on the Web at <www.journals.cambridge.org> by clicking on "Take the tour," then "Journal list," then "Psychological Medicine." ■

Testosterone May Boost Efficacy Of Antidepressants in Men

Testosterone gel may produce antidepressant effects in men who are not responding to conventional medication.

BY JOAN AREHART-TREICHEL

When middle-aged men are depressed and antidepressants don't help them, there may be another effective treatment for them—testosterone.

Indeed, this is what Harrison Pope Jr., M.D., chief of the Biological Psychiatry Lab at McLean Hospital in Belmont, Mass., and coworkers found in a small, preliminary study. They reported their results in the January *American Journal of Psychiatry*.

"These preliminary findings," they wrote, "suggest that testosterone gel may produce antidepressant effects in the large and probably underrecognized population of depressed men with low testosterone levels."

Past studies have shown that some depressed men have low blood levels of testosterone. Men with underdeveloped testes often show depressive symptoms, and testosterone replacement may improve these symptoms. This tantalizing evidence, combined with the fairly recent availability of testosterone supplementation via a transdermal gel, prompted Pope and his coworkers to undertake an exploratory study. They wanted to see whether a testosterone gel might counter depression in men who hadn't gotten relief from antidepressants and who had testosterone levels on the low side for their age.

First Pope and his colleagues attempted to recruit, via radio ads and clinical referrals, potential subjects for their study. They were interested in men between 30 and 65 years of age who were experiencing a major depression and who were not receiving any relief from antidepressants. Fifty-six men expressed interest in participating in the investigation. Pope and his coworkers then tested each of the 56 men for morning blood levels of testosterone; 24 (43 percent) had borderline or low levels for their age (350 ng/dl or less).

Twenty-two of these men were then entered into the study, and they continued to take the same antidepressants that they had taken before. But in addition, 12 were randomized to receive 10 gms of a 1 percent testosterone gel daily for eight weeks, and the remaining 10 were randomized to receive a placebo gel daily for eight weeks. The researchers then tracked the subjects' depression during the eight-week treatment period, using the Hamilton Depression Rating Scale, the Clinical Global Impression severity of illness scale, and the Beck Depression Inventory.

The subjects getting the testosterone gel improved, on average, significantly more than the subjects on a placebo, according to the Hamilton Depression Rating Scale. The improvement was evident on both the psychological aspects of depression, such as depressed mood, anxiety, or guilt, and on the somatic aspects of depression, such as sleep, appetite, and libido. The subjects getting the gel also showed, on average, a significantly greater rate of decrease in scores on the Clinical Global Impression severity of illness scale, but not on the Beck Depression Inventory.

Thus, it looks as if a testosterone gel might be able to help some depressed middle-aged men who receive no relief from an-

please see ***Testosterone*** *on page 38*

Public Education Justified

Recent events concerning hostilities with Iraq have raised the question, "Can we as psychiatrists speak out about foreign policy, and if so, under what circumstances and in what ways?" We would like to share our position on this question and why we believe that, as experts in psychology, human emotions, behavior, and mental distress, psychiatrists are compelled to participate in the debate.

First, we know about the psychological and social consequences of war and trauma. War places combatants, witnesses, and survivors at risk for various mental disturbances: posttraumatic stress disorder (PTSD), depression, stress-related psychosis, anxiety, neuropsychiatric consequences of exposure to neurotoxic agents, exacerbation of preexisting psychiatric illness, and so forth. Families of combatants and other survivors must deal with grief and bereavement, as well as societal dislocation and distress. War increases the likelihood of enemy retaliation, which in turn exacerbates public anxiety and dysphoria. If retaliatory acts occur, there will be predictable increases in PTSD and depression. War diverts government spending to the military and enlarges the budget deficit. Higher military budgets often result in reductions in domestic social programs, such as mental health services, unemployment insurance, public assistance, Medicaid, and Social Security supports.

Second, the decision to go to war is complex and susceptible to irrationality. As experts in coping with adverse situations, we can help evaluate such decisions by providing a focus on the emotions, motivations, expectations, and understanding involved.

Our psychiatric expertise qualifies us to predict the tragic psychosocial consequences of war and to consider the decisions leading to war. Policymakers and the U.S. public need to understand the decisions leading to war and the possible consequences when considering whether to support our leaders in their efforts to initiate, continue, or expand warfare.

CONCERNED PSYCHIATRISTS AND MENTAL HEALTH PROFESSIONALS

Editor's note: There are 50 original signatories to this letter. Anyone wishing to see the names of the signatories can contact Carl I. Cohen, M.D., at cohenhenry@aol.com or Psychiatric News *at pnews@psych.org.*

Patient Safety

I would like to comment on the article in the September 20, 2002, issue headed "APA Developing Recommendations to Improve Patient Safety." The article addressed safety regarding psychiatric units.

Duration of stay anywhere in a general hospital has significantly decreased to just a very few days. So much must happen within this time. Frequently, no one acts to orchestrate collaboration for each patient on every medical or surgical unit to help maintain the psychosocial aspect of safety for every patient.

It is my belief from public health, preventative health, community mental health, and systems perspectives that psychiatric departments and/or departments of behavioral health associated with general acute care facilities should feel partly responsible to help prevent psychosocial sentinel events throughout the general hospital. This might entail the interaction of administrative direction, hiring practices, cooperation between registered nurses, and assistant personnel, as well as involvement of families, staff physicians, and the community at large.

Some specific topics that might be addressed through continuing dialog with administrations and/or participation in in-service training are the following:

- Hospitals might provide an informed consent to patients regarding the recruitment of competent family members, friends, or privately hired personnel as a possible valuable adjunct in the patient's room to help facilitate the safety net. Hospital staff would need training in how to include this type of assistance. Perhaps creating specific volunteer programs to assist when no one else is available would be useful. Why should informed consent be required only by professionals about to do special procedures within hospitals?

- Hire licensed practical nurses (LPNs) and unlicensed assistive personnel (UAPs) according to "acuity" of care needed and not according to the number of patients on a unit.

- Hiring for "acuity" might cost approximately $28,000 (plus benefits) for each such additional personnel instead of the national average of $42,000, or $64,000 for specialty trained registered nurses.

- Patients and hospitals might benefit if decisions regarding "acuity" were a joint decision between physicians and nursing departments.

- Registered nurses could more frequently support LPNs and UAPs in their efforts to advocate better safety for their patients.

- LPNs and UPNs should not be rotated or "floated" to other units so that patients have continuity of care.

- More outreach by hospitals sharing their

please see ***Letters*** *on page 28*

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.

from the president

continued from page 3

being done by psychiatrists. The percentage of research grants in mental health that go to psychiatrists is the lowest it has been in decades. Established researchers are finding it hard to recruit residents into research careers. The high debt burdens that many residents carry—averaging $95,000 in 2000 and often much greater—is undoubtedly part of the reason they elect to forego research fellowships for the greater immediate rewards of clinical practice. A typical stipend for a federally supported research fellowship is $38,628 a year.

Another factor is the uncertainty regarding funding for a research career. Times have been good over the last five years, but what comes next? For many young would-be investigators, staking their careers on the uncertainties of the next R01 application seems too great a risk. Thus, M.D. postdoctoral trainees supported by NIMH have decreased by 50 percent since 1992, from 342 to 210. Where will the money come from to support those careers?

Research, for most academic departments, is not a money-making enterprise. To the contrary, it typically takes dollars from department budgets to support the research effort. Since the growth of medical research in the United States in the years following World War II, with the creation of the National Institutes of Health (NIH), academic departments subsidized their researchers—particularly those early in their careers—with dollars generated from clinical endeavors. But with clinical work no longer covering its costs or breaking even at best in many places, the surpluses that once enabled young faculty to get on their feet, more established faculty to be carried through lean periods, infrastructure to be built, and pilot studies to be conducted no longer exist.

Faculty members, who once were expected to do clinical studies, write papers, and generate grant proposals during the work week, along with taking care of their clinical responsibilities, are now so stressed merely by the need to meet their quotas of patients, revenues, and RVUs that they have no time left to foster their research careers. Without relief from these pressures, medical research—but because of the greater financial stresses that we confront, psychiatric research in particular—faces a future much less bright than it might have been.

How do we reverse these pressures that have squeezed American academic medicine—the envy of the medical world—to the point where the viability of many academic research centers is endangered? Part of the answer, of course, is to infuse back into the psychiatric treatment system the resources that have been systematically stripped from it over the last 15 years. The reductions in payments and increases in costs caused by managed care and government cutbacks have not only created a crisis in access for patients, but also threatened the research (and education, another topic worth separate consideration) enterprise on which the future of psychiatry and all of medicine depends. Payers, whether governmental or private, must recognize the necessity of paying rates that not only cover the direct costs of care, but also support the infrastructure on which viable treatment, research, and training enterprises all rest.

Direct support of research is another piece of the answer. Over the last five years, Congress has nearly carried out a commitment to double the NIH budget. At this writing, we await congressional action on the last installment of that promise, embodied in the Fiscal 2003 appropriation. It is important for the future of American medicine that this commitment be fulfilled. However, we are now told that the Bush administration plans to recommend that next year's budget not even cover the costs of inflation—representing a real decrease in the dollars available for research support. Such an outcome would be tragic.

Young people looking to careers in psychiatric and other medical research need to know that the dollars to support their investigations will be there next year and the years after that. Allowing the tap to run full and then go dry does nothing but convince researchers early in their careers of the looming insecurity of a research position. It dissuades departments and medical schools from investing in research facilities. It slows the pace of knowledge acquisition and application. Boom and bust is no happier a scenario in the laboratory or clinical research unit than it is on Wall Street.

APA has been working with a coalition of groups to encourage Congress to complete the process of doubling the NIH budget. You can help by going to the APA Web site at <http://congress.nw.dc.us/psych/home/> and sending a message on this subject to your representatives in Congress, using the automated e-mail software accessible at this site. (Another way to access this feature is to go to <www.psych.org/pub_pol_adv/index.cfm> and click on "Advocacy Action Center.") APA is also preparing for the next stage of the fight: convincing the Bush administration and Congress of the importance of sustained support for research. Anyone who sees patients knows that we have a long way to go. ■

letters to the editor

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challenges with the community and requesting community oversight in addition to input from their hospital boards might well facilitate improved patient safety. This could include joint hospital, physician, and community participation in nursing personnel exit interviews.

I believe that the suggestions I have made do not conflict with the JCAHO's notion of voluntary omission of error and the simultaneous confidentiality that is conferred. I envision a slow process, constructive and not punitive, as hospital and community evolve together.

With the above in mind, I am hoping that hospitals throughout the United States adopt the Institute of Medicine's "patient-centered" recommendations.

JOHN M. ACKERMAN, M.D.
Santa Barbara, Calif.

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Army

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Physics Laboratory in Baltimore.

Living Works Education began collaborating with the Johns Hopkins lab to create software allowing ASIST trainees in the Army to refine their skills by practicing the intervention on a "virtual" person.

Tim Frey, who is the program manager of Human Interaction Simulation Training at the lab, told attendees at the Department of Defense suicide prevention forum that 1,600 video clips were taped in the production of the software of an actor posing as "Billy," the virtual person who may be at risk for suicide.

"The simulated subject has a number of responses ready for any question posed to him," Frey said. "We wanted to give the subject a brain so he could respond to comments and questions in a realistic, believable, and humanlike way."

The software package is composed of three compact discs and a manual corresponding to the ASIST training. Billy appears on the computer screen as the person at risk and responds to the words of the trainee through a voice-recognition mechanism.

After introducing Billy as a 22-year-old infantryman experiencing marital difficulties, Frey posed as an ASIST trainee and demonstrated the software for his audience. "Hi, Billy, thanks for stopping by," he said into a microphone attached to his laptop. "Do you have time to talk?"

During the course of the conversation, Frey discovers that Billy has been arguing on a frequent basis with his wife and is facing disciplinary action on the job. He also finds out that Billy thinks about suicide all the time. He questions Billy about the activities he enjoys and the people with whom he is particularly close, using the positive aspects of Billy's life to keep him from thinking about suicide until Billy can get help from an expert.

Swanner said the software is valuable because an ASIST trainee will never have the same interview with Billy two times in a row. "You never know how he will respond," he said, noting that sometimes during the virtual interview Billy is at risk for suicide and sometimes he is not.

The software also has a feature that scores trainees on their intervention skills as they conduct the intervention. The scoring is based on how closely trainees adhere to the ASIST model, Swanner said.

The Applied Physics Lab originally developed the human simulation software to train FBI agents to interview potential suspects and determine when a suspect was lying, Frey said

The Army, through the U.S. Materiel Command in Alexandria, Va., began distributing the software to its personnel in January.

"Our goal is to provide an experience that is realistic and that reinforces training," Frey said, "so that by the time you are with a real subject, you've had time to practice and have already made your mistakes."

Additional information about the ASIST suicide prevention model can be found on the Living Works Education Inc. Web site at <www.livingworks.net>. ■

Michigan

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private hospitals.

Closing Northville is not the state's first brush with controversy. In the past 10 years the Engler administration has closed 10 of the state's 15 psychiatric hospitals. Several groups tried to block the closings by court order but failed, turning hundreds of people over to inadequately staffed and underfunded support networks.

Not everyone was upset by the decision to sell Northville. Township supervisor Mark Abbo admitted that some people had lost patience with the hospital because patients issued passes had wandered away and some had become involved in car jacking, assaults, robberies, and other crimes. But most have proven harmless.

Haveman said that the best practice is providing community-based services. "We made tough decisions to close all those institutions and lay off 5,000 people. But Michigan today is a national leader. People say it's a failed policy, but I say, 'Compared with what?' Show me a state that's done better."

Robert Geake, a former state senator from Northville, said that hospitals are important because a segment of the mentally ill should never be placed in neighborhood settings now commonly used for the developmentally disabled, drug abusers, and paroled criminals.

"There needs to be an acceptance of mental illness, rather than believing it is someone's fault."

Contrary to claims by politicians that closing large state psychiatric hospitals is based on economy, H. Richard Lamb, M.D., a professor of psychiatry at the University of Southern California, said that it is merely cost shifting.

"While the number of beds has gone down, the number of people in jail has gone up. So really you are not closing a bed, you are just moving it. I wouldn't think it is cheaper to keep someone in the criminal justice system than in hospital. Besides, you have all that security to pay for. And as far as treating people is concerned, you can't treat people really well in jail.

"So it is not an economy—it's cost shifting. That's my opinion. These are people who are against hospitals, but they are not much against having people in jail." ■

Erratum

The state with a new tort reform law reported in the December 20 issue is Mississippi, not Missouri. The law imposes a $500,000 cap on damages for pain and suffering and grants malpractice immunity to physicians if they have prescribed an FDA-approved drug. It also abolishes joint and several liability for noneconomic damages and reduces it for actual economic damages. ■

Psychotropics

continued from page 1

cific class of medication and the particular system analyzed. Confirming previous reports, the data revealed significant variations in prescribing patterns within and between systems and geographic locations. During the latter half of the study period, however, significant growth across the entire study population was seen in the use of α-agonists, mood-stabilizing anticonvulsants, and neuroleptics.

By the end of the study period in 1996, the use of any psychotropic medication among youths under 20 years old was similar across the three systems studied: Between 5.9 percent and 6.3 percent of all youths were prescribed at least one psychotropic medication during the study period. In all three populations, stimulants and antidepressants were ranked first and second, respectively, in terms of total prescriptions.

Youths covered through the two Medicaid systems studied had consistently higher rates of prescribing for α-agonists, neuroleptics, mood-stabilizing anticonvulsants, and lithium. Youths in the HMO had similar rates of prescriptions as those covered by Medicaid for both antidepressants and hypnotics.

Over the course of the 10-year study, greater increases were seen in females receiving prescriptions for stimulants and for males receiving prescriptions for antidepressants. This could reflect, Zito said, a growing recognition that these disorders are not believed to be more prevalent in one sex or the other.

More Questions Than Answers

"The most useful role that these data play are to generate hypotheses about the evidence base that we have," Zito told *Psychiatric News*, "and the motivation behind this prescribing. It is hoped that this process will shed some light on those variations."

Zito acknowledged, however, that the study does not attempt to conclude whether the data represent overprescribing, underprescribing, or appropriate or inappropriate prescribing practices.

"It certainly is a question of appropriateness, but I am just putting the data out there," Zito continued. Data from other studies have indicated that the vast majority of these medications are not prescribed by psychiatrists; they are prescribed by pediatricians and family practitioners, she said.

"Psychopharmacology—as a cottage industry of sorts—has a very high level of sophistication and understanding of how these medications work in the body and the brain," Zito said. "But we don't have anywhere near that level of sophistication yet in figuring out how these medications are actually used in clinical practice."

In an accompanying editorial, Michael Jellinek, M.D., chief of the child psychiatry service at Massachusetts General Hospital, noted that while the data presented by Zito and her colleagues are useful, they are dated. Jellinek called for an up-to-date "health plan by health plan quality assurance effort, and a health services and basic research program," a notion Zito told *Psychiatric News* that she strongly supports.

"We undertake such activities in many areas of medical care, more for adults than for children," Jellinek wrote. "Will we value our children sufficiently to ask if we are prescribing the right psychotropic medications to the right children using the right treatment plan?"

Coding Data Inadequate

Zito and her colleagues have *ICD-9* codes available matching each prescription in their data set to specific diagnoses; however, she doubts that a coding analysis will reveal much about the appropriateness of prescribing.

Peter Jensen, M.D., the Ruane Professor of Child Psychiatry and director of the Center for the Advancement of Children's Mental Health at Columbia University/New York State Psychiatric Institute, agreed that coding data are inherently flawed.

"The real critical issue here is not the chart diagnosis, although that would be useful," he told *Psychiatric News*. "But sometimes people use the chart diagnosis because that's how they're going to get the claim paid."

Even if the patient's chart carried an *ICD-9* code for attention-deficit/hyperactivity disorder, he said, it doesn't mean that the child has had a complete and thorough psychiatric evaluation to back up the diagnostic code.

APA Trustee-at-Large David Fassler, M.D., a Burlington, Vt., child and adolescent psychiatrist, agreed with Jensen and Jellinek. "The real question here shouldn't be, 'Are we treating too many children?, but rather, 'Are we treating the right children?' "

Fassler, a member of the governing council of the American Academy of Child and Adolescent Psychiatry, noted that the academy's guidelines on comprehensive evaluations emphasize that an evaluation often involves more than one visit and may last several hours. "This is not an assessment that can realistically or appropriately be done in a five- or 10-minute visit in the context of a busy pediatric or primary care practice," Fassler said.

More Training Needed

Both Jensen and Fassler told *Psychiatric News* that the real importance of the Zito study is to draw attention to an important issue that needs to be studied in much more detail.

"I will say," Jensen noted, "that we have enough evidence from a variety of other settings—though not from Dr. Zito's study—that there are problems in the use of these medications under some circumstances. You can look at clinicians' treatment of this or that disorder and see that frequently medications are underused or overused."

Correcting those problems, Jensen said, is a matter of educating and training the family practitioners and pediatricians who are writing the vast majority of the prescriptions. His team at Columbia, as well as at numerous other centers, are working on projects to facilitate and improve that process.

"With Prozac recently being approved down to age 8, and other studies of Paxil and Zoloft and such that are showing at least some modest efficacy in children, the likelihood of increased prescribing by primary care providers has simply been staring us in the face," Jensen said. "For good or ill, that's how it has been, and that's probably how it's going to continue to be."

With an estimated 7,500 child and adolescent psychiatrists in the United States and a population of 72 million under the age of 18, Jensen said, the numbers just don't work—specialty consultation and comprehensive evaluation simply can't be done for all of the estimated 12 million to 17 million children and adolescents with a psychiatric disorder.

"We also know," Jensen emphasized, "that the managed care environment has had a huge impact on what is done and how it is done."

Added Fassler, "Research has consistently demonstrated that child and adolescent psychiatric disorders remain underrecognized, underdiagnosed, and undertreated. Literally millions of children receive no treatment whatsoever. This is the real tragedy, since we can help many, if not most, of these kids."

An abstract of "Psychotropic Practice Patterns for Youth: A 10-Year Perspective" is posted on the Web at <http://archpedi.ama-assn.org/issues/current/abs/poa20275.html>. ■

professional news

Ecstasy

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The attacks have also been linked to increases in certain types of mental disorders and chemical dependency in New Yorkers, according to researchers at the New York Academy of Medicine. However, Johnston said the population he studied is fundamentally different.

He told *Psychiatric News*, "It is possible a shock like 9/11 could have opposite and anomalous effects on people at two ends of the drug-using spectrum."

For example, one sample in New York involved adults "who may already have developed a pattern of using substances to cope with life's vicissitudes" and "in whom drug use might be increased with additional stress."

The Monitoring the Future Study, in contrast, samples youth "who have not yet started or are at the beginning stages of drug involvement—and are therefore more likely to have their use motivated by sensation seeking and social partying." The shock resulting from the terrorist attacks, he speculated, might cause such youth to be deterred from pursuing such potentially harmful activities.

Charles Curie, head of the Substance Abuse and Mental Health Services Administration (SAMHSA), said the effects of prevention efforts launched at the national level by the Bush administration are taking hold at the local level in communities around the nation.

"It is gratifying to see the president's national drug control strategy. . .is beginning to take hold, and our investments in partnership with states, communities, parents, schools, and faith-based organizations are beginning to pay off," he said at the press conference.

He named SAMHSA's State Incentive Grant Program and its National Registry of Effective Prevention Programs as examples of how such partnerships fund and keep track of successful substance abuse prevention programs.

"At NIDA, we will continue our efforts to improve prevention strategies through research," said Hanson. "To keep drug use trends moving in the right direction, we must all remain vigilant and continue to work toward improving and adopting science-based strategies to accelerate the progress we've already made."

More information about the 2002 Monitoring the Future Study is posted on the Web at <monitoringthefuture.org>. ■

clinical & research news

Testosterone

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tidepressants and who also have low levels of testosterone, Pope and his team concluded.

They also suspect that "low testosterone levels may be unexpectedly common in middle-aged men with treatment-resistant depressive disorder" since almost half of the 56 men who had been interested in participating in their study had borderline or low testosterone levels.

As far as negative side effects were concerned, one subject on testosterone reported difficulty urinating, suggesting that the testosterone was possibly exacerbating a case of benign prostatic hyperplasia. None of the other 11 subjects getting testosterone, however, reported any adverse effects. Thus, short-term treatment with testosterone gel appeared to produce minimally unfavorable effects.

This preliminary study, of course, did not answer some crucial questions, the researchers noted. For instance, what effect would testosterone supplementation over a longer period have on depression? Would it help depressed men not taking antidepressants, or would it be more useful as an adjunct to antidepressant treatment? Would giving testosterone over the long haul aggravate benign prostate hyperplasia or increase the risk of prostate cancer? And finally, how might testosterone counter depression? "It is too early to speculate," Pope told *Psychiatric News*, "because it is a very idiosyncratic response in that some of our subjects responded dramatically, whereas others had absolutely no effect."

Given the positive results from this preliminary study, however, and the potential public health benefits that might accrue from them, the value of testosterone as a depression treatment should definitely be explored, Pope and his team believe.

The study report, "Testosterone Gel Supplementation for Men With Refractory Depression: A Randomized, Placebo-Controlled Trial," is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/160/1/105>. ■

community news

Employment

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ing the client come in and perform one or two tasks a couple of days per week. But the job is not advertised that way. It wasn't a job someone was working already—we went in and made the job."

Deborah Becker acknowledged that few of the clients work full-time jobs, but said this isn't necessarily due to the severity of their psychiatric illness. The most common reason that the clients work on a part-time basis, she said, is that full-time work could disrupt Social Security disability payments and Medicaid benefits.

Of the 42 clients receiving services at the Santee-Wateree program, 14 are currently employed, said Grate-Pearson. While about three to five clients are unable to search for work because of health or other reasons, the remaining clients are actively involved in a job search.

She has clients who work at a local Air Force base—one as a mail clerk and the other as a janitor; another who cleans rooms at a local hotel "loves to get out of the house each day" to go to work and is heavily praised by the hotel management team.

"Even though some of them make as little as $16 a week," said Grate-Pearson, "the clients are ecstatic when they get their first paychecks."

More information about the Johnson & Johnson-Dartmouth Community Mental Health Program can be obtained by contacting David Lynde by e-mail at David.Lynde@Dartmouth.edu. ■

Minnesota

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state contributed to inpatient care for the uninsured and now will be legally obligated to absorb the costs of caring for those patients.

David Matteodo, executive director of the Massachusetts Association of Behavioral Health Systems, told *Psychiatric News*, "We lost 96 private beds last year and will lose another 150 public beds in 2003 with the closing of a state hospital and state inpatient units. The dam hasn't burst yet, but it's near the breaking point."

He added that as of April 1, Massachusetts will eliminate Medicaid coverage for about 50,000 unemployed, low-income adults, which will expand the number of uninsured and place further financial strains on hospitals and other sources of health care.

In Virginia, 312 inpatient beds in state psychiatric hospitals closed in 2002, and 161 acute-care psychiatric beds in private hospitals closed in 2001 and 2002, according to a report in the November 7, 2002, *Richmond Times-Dispatch*.

The president-elect of the Psychiatric Society of Virginia, J. Gregory Fisher, M.D., told *Psychiatric News* that access to inpatient care for children and adolescents had become considerably more difficult during the last five years.

Fisher is a child and adolescent psychiatrist at Virginia Baptist Hospital in Lynchburg.

"If our unit is full, we might have to call six or seven hospitals to find a bed," he said. "It's a time-consuming process, and the child often is languishing in the emergency room while we get the approvals we need. Sometimes, the only available bed is at the other end of the state."

Another psychiatrist at Virginia Baptist Hospital, Randall Scott, M.D., described a series of problems. "The workload has tripled in the last five years. The closest state hospital receives referrals from 13 community mental health centers. Because of the great demand for beds, state hospitals establish their own rules about whom they will accept. Western State Hospital, for example, will not take patients who have any form of insurance, including Medicaid."

Scott said that patients are "sicker" when they arrive because of interrupted or no treatment. He added, "It's a misconception to think that treating people in the community will eliminate the need for hospitals. There are patients who are visited twice a day by PACT teams and still need hospitalization periodically."

APA President-elect Marcia Goin, M.D., told *Psychiatric News* that there are 230 psychiatric beds in the public sector in Los Angeles County, which has an estimated population of 10 million people. As many as 30 patients sometimes are housed in psychiatric emergency rooms that are licensed for eight patients.

Meanwhile, according to Goin, the Los Angeles County Jail houses 2,300 inmates who are taking psychotropic medication and 100 additional inmates who refuse to take such medication, although it has been prescribed.

Goin said, "These figures illustrate what has been called the criminalization of the mentally ill. When psychiatric beds and other mental health services are not available, people with serious mental illness go untreated and often self-medicate with illegal drugs. In their confused state, they commit crimes or engage in other activities that result in incarceration."

Last November, she urged members of the President's New Freedom Commission on Mental Health to consider the idea that dollars directed to the mental health system could result in savings for the criminal justice system *(Psychiatric News*, December 6, 2002).

"The recommendations in the commission's final report, which will be released in May, could affect the mental health system for many years. I hope APA members will take advantage of the opportunity to let commission members know about problems of access in their states," she said. (See contact information at the end of this article.)

These accounts are supported by data in the 2002 Annual Survey Report of the National Association of Psychiatric Health Systems (see box above).

In related news, last month the Kaiser Commission on Medicaid and the Uninsured released the results of a survey in a report titled "State Fiscal Conditions and Health Coverage: How Are Budget Pressures Putting the Squeeze on Medicaid and SCHIP Programs?" It noted that 49 states and the District of Columbia were planning or had implemented cuts in Medicaid for Fiscal 2003. Thirty-two states reported making cuts twice.

Among the cuts are provider payment reductions (37 states), prescription drug cost controls (45 states), benefit reductions (25 states), increased copayments (17 states), and reductions in support for long-term care (17 states).

State budget shortfalls are expected to increase from $37.2 billion in Fiscal 2002 to $60 billion in Fiscal 2004, according to data presented at the press conference.

On January 9 seven senators introduced S 138, which would increase the federal medical assistance percentage for the Medicaid program by 2.45 percentage points for the last two calendar quarters of Fiscal 2003 and all of Fiscal 2004. The bill would also authorize the appropriation of $10 billion to provide states with temporary grants for fiscal relief.

The Bush administration has opposed any increase in the federal share of Medicaid, claiming that the federal government has fiscal problems of its own, according to the January 13 *New York Times*.

Numerous studies about Medicaid issues are posted at <www.kaisernetwork.org> under "HealthCast" and "Health Policy." Comments can be posted at <www.mentalhealthcommission.gov/comments.html>. Goin would like to receive a copy of comments, which can be sent to her via e-mail at mgoin@hsc.usc.edu. ■

Hospital Occupancy Rates Up

Occupancy rates in hospitals providing inpatient care for patients with psychiatric and substance abuse disorders have climbed to historic levels, according to the 2002 Annual Survey Report of the National Association of Psychiatric Health Systems (NAPHS).

In 2001 the average occupancy rate was 74.1 percent, which is a 7.1 percent increase over the 2000 rate. The 2001 occupancy rate is 36 percent higher than the average rate five years ago.

The NAPHS report is based on responses to the association's annual questionnaire distributed in the summer of 2002. Of the 328 facilities polled, 136 facilities responded, yielding a response rate of 41.5 percent.

NAPHS members include behavioral health care provider organizations, such as specialty hospitals, general hospital psychiatric and addiction treatment units, residential treatment centers, and other providers of care.

Payment is up for the first time in five years, according to the report. Average inpatient net revenue in 2001 increased 9.7 percent to $556 a day.

In a press release announcing the report, NAPHS Executive Director Mark Covall said, "This turnaround is indicative of the growing demand for acute hospital care within all age groups (including children, adolescents, adults, and older adults) and the reduction in capacity as beds have been closed in both the public and private sectors."

After stabilizing in the past few years, the average length of stay in 2001 declined to 9.3 days, from 10 days in 2000. Overall median lengths of stay declined 4.3 percent to 8.8 days in 2001. Over the past decade, hospital lengths of stay went down 53 percent, from 19.8 days in 1992 to the current 9.3 days.

The percentage of responding institutions offering partial hospitalization and outpatient services has declined. While 82.5 percent (or 99) of survey respondents in 2000 offered partial hospitalization services and 64.2 percent offered outpatient services, in 2001 the percentage of respondents offering partial hospitalization services was only 66.7 percent (or 84), and the percentage offering outpatient services was only 49.2 percent.

It should be noted that some institutions did not respond in both years.

Almost half (48.1 percent) of admissions to respondent hospitals were supported by state or federal programs. Patients supported through Medicaid or Medicare programs accounted for 42.1 percent of all inpatient admissions in 2001.

The report is available for $400 from NAPHS at 325 Seventh Street, N.W., Washington, D.C. 20004-2802.

professional news

Malpractice

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Scranton," Bush said. "And that's why we need a cap on noneconomic damages, and that's why we need a cap on punitive damages as well. . . .[I]t is the fear of unlimited noneconomic damages and punitive damages that cause docs and the insurance carriers to unnecessarily settle these cases. . . .In cases where more than one person is responsible for a patient's injuries, we need to assign blame fairly. We need joint and several liability reform in our medical liability system."

Million-Dollar Awards

Levenson and others say the steep increase in malpractice premiums across specialties appears to be related less to rising numbers of claims than to increasing costs for legal services and dramatic increases in jury awards—but also to complex factors related to the way the insurance industry does business.

The AMA cites research by Jury Verdict Research showing that in 1999 jury awards in claims cases jumped 7 percent in one year. In addition, it cost 30 percent more to settle a suit than it did just a year previously. About 45 percent of the 1998-99 jury awards were for $1 million or more, up from 39 percent during the preceding 12 months.

Martin Tracy, J.D., president and CEO of Professional Risk Management Services Inc., noted that while premiums are higher today than many physicians are used to, they are still lower in real dollars than they were 10 years ago.

Nonetheless, Tracy said that the crisis is real. During the late 1990s, when the economy was flush, insurance companies practiced "cash-flow underwriting"—using competitive pricing to attract enrollees, then using the premiums collected up front to invest in a bull market, he said.

"Today, diversified insurance companies can no longer anticipate double-digit investment income, so they are collecting more money up front," he said.

He echoed Levenson in saying that the rising tide of malpractice premiums is lifting all boats. "I would not want to leave anyone with the impression that psychiatric malpractice exists in a special universe," he said. "Most insurance companies that write malpractice don't focus a lot on psychiatric malpractice as a separate entity, so when they raise rates, they raise them for all specialties."

Levenson added that most major insurance carriers offer more than medical malpractice coverage, so they are affected by rising costs for other types of claims as well.

California Experience

Medical Insurance Exchange of California (MIEC) of Oakland, Calif., which insures approximately 1,000 psychiatrists, reports a 7 percent increase in premiums this year, due to many of the reasons cited by Levenson and Tracy. "Through the 1990s, premiums were stable or went down in California," said MIEC Vice President Ron Neupauer. "But along with inflation we have seen an uptick in the number of large verdicts, while legal costs have also risen."

MIEC is a physician-owned company that operates in five Western states.

Neupauer noted that physicians in California have benefited from the Medical Injury Compensation Reform Act (MICRA), passed in the wake of a malpractice crisis in that state in 1975. He says the law has "moderated the lottery system that occurs in other states in which a plaintiff can get a million-dollar award if [he or she has] a sympathetic jury."

He explained that the law has four essential components: It caps noneconomic damages at $250,000, limits legal contingency fees along a sliding scales, allows offsets against a settlement if a plaintiff has other forms of recovery such as health insurance, and allows for future damages to be paid over time, instead of all at once.

Levenson and others say tort reform, such as California's MICRA, is essential. "This is something APA and district branches need to be involved in," he told *Psychiatric News*. "It is not only a national issue but a state one as well."

In particular, Levenson said limits on noneconomic damages for pain and suffering were critical targets. Another area ripe for reform is that of "joint and several liability." In a number of states, he said, a physician may be liable for a claim even though a hospital or other employer is also responsible. ■