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Volume XXXVIII
Number 6
March 21, 2003

Newspaper of the
American
Psychiatric
Association

PSYCHIATRIC NEWS

"See" references appear on pages 1, 10, 16, 17, 25, 31

Riba, Ruiz Head List Of New APA Officers

The results of APA's 2003 election were officially announced earlier this month. In addition, APA members voted to downsize the Board by two trustees.

Association News

BY CATHERINE F. BROWN

Michelle Riba, M.D., of Ann Arbor, Mich., was chosen by APA members to be their next president-elect for the term beginning in May. She defeated Fred Gottlieb, M.D., of Los Angeles with 53.2 percent of the vote.

Michelle Riba, M.D. (left), will become APA's president-elect at the end of APA's 2003 annual meeting in May, when Marcia Goin, M.D., assumes the presidency.

Riba, who is currently APA's senior vice president, is the associate chair for education and academic affairs and a clinical associate professor in the department of psychiatry at the University of Michigan and director of the psycho-oncology program at the University of Michigan Comprehensive Cancer Center.

Riba outlined an ambitious agenda for her presidential term in an interview with *Psychiatric News*. What she most hopes to accomplish during her presidency, she said, is to increase APA's membership.

"One hundred percent of eligible psychiatrists and trainees must realize the *privilege* and *benefits* of belonging to APA, the premier organization of psychiatrists in the world. I plan on working with our membership components" to accomplish this goal.

Apart from strengthening the membership base of APA, Riba also plans to devote attention to key areas within psychiatry, particularly psychiatric education.

"We must reinvigorate our efforts in psychiatric education at the undergraduate, medical school, and postgraduate levels," she said. "I look forward to working with Jay Scully, M.D., APA's medical director; and Deborah Hales, M.D., head of APA's Division of Education, Minority, and National Affairs; and leaders of our psychiatric allied organizations in setting a national agenda for psychiatric education. It is time for a national summit where we can address important topics such as the upcoming Institute of Medicine recommendations on psychiatric research training for adult and child and adolescent residents, funding for psychiatric training, careers in psychiatry, and so on."

She said she is also "looking forward to working with Darrel Regier, M.D., head of APA's American Psychiatric Institute for Research and Education, and the National Institute of Mental Health on effecting some of the upcoming recommendations of the Institute of Medicine Committee report on psychiatric research in adult and child psychiatry residencies, chaired by Thomas Boat, M.D."

Other areas on which Riba plans to concentrate are public advocacy and funding for mental health care and access to high-quality psychiatric care.

The race to succeed Riba as one of APA's two vice presidents was won by Pedro Ruiz, M.D., of Houston. He defeated Norman Clemens, M.D., of Cleveland, with 63.8 percent of the vote. Ruiz

please see ***Election Results*** *on page 17*

Grand rounds moves out of its traditional format and into cyberspace with the launching of APA's latest continuing medical education program. Now members can earn CME credit free by participating in online discussions on selected topics.

See story on page 18.

Parity Advocates In Congress Vow To Pass Bill In 2003

Government News

In a bipartisan effort to pass comprehensive parity legislation this year, two bills that mirror the 2001 legislation were introduced last month in the Senate and House of Representatives. The cosponsors urged swift passage.

BY CHRISTINE LEHMANN

The Senator Paul Wellstone Mental Health Equitable Treatment Act was introduced in Congress last month in honor of the late senator who was a passionate advocate for parity and mental health treatment. Wellstone died in a plane crash last October while on the campaign trail.

Sens. Pete Domenici (R-N.M.) and Edward Kennedy (D-Mass.), a ranking member of the Senate Health, Education, Labor, and Pensions Committee, joined with Reps. James Ramstad (R-Minn.) and Patrick Kennedy (D-R.I.) at a press briefing last month to announce their plan to get Congress to pass a parity bill this year.

The parity bills, which were introduced late last month, prohibit health plans from imposing greater restrictions on treatment and more severe financial requirements on patients with mental illness than they do for patients with other types of medical illness (see box on page 49).

The bills closely mirror the 2001 parity legislation that passed the Senate but stalled in House committees controlled by Republican leaders. Republican leaders had objected to "parity mandates" because of the belief that they would increase health

please see ***Parity*** *on page 38*

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Court Allows State to Medicate Death-Row Inmate Forcibly

Legal News

A federal appeals court muddies the perennially troubled waters swirling around the issue of medicating psychotic prisoners who could then be executed if they regain mental competence.

BY KEN HAUSMAN

Arkansas prison officials have won the right to force severely mentally ill inmate Charles Singleton to take antipsychotic medication, so he will regain enough of his sanity to understand that he will soon be executed.

This action will take place as the result of a February 10 ruling from a federal appeals court saying that involuntarily medicating a psychotic death-row inmate as a prelude to putting him to death does not violate the U.S. Constitution.

Barring a successful appeal to the U.S. Supreme Court, Singleton's fate was sealed by a divided appeals court—the St. Louis-based 8th Circuit—that voted 6 to 5 in favor of Arkansas' contention that it should be allowed to medicate Singleton forcibly.

APA President Paul Appelbaum, M.D., thinks the court came to a wrong and troubling conclusion. "Physicians violate their ethical obligations as healers when they treat condemned prisoners for the purpose of restoring competence to be executed," he told *Psychiatric News*. "The only humane alternative in these situations is for the state to commute the prisoner's sentence to life in prison, so that treatment can take place without being darkened by the shadow of death."

He pointed out that this is the position both APA and the AMA have taken on this issue.

Howard Zonana, M.D., medical director of the American Academy of Psychiatry and the Law and a professor of psychiatry at Yale University, said he was "distressed" by the ruling. "It makes something legal that in certain circumstances is clearly unethical," he said. "Psychiatrists need to be aware of the AMA ethical guidelines on this issue and of APA's participation in their preparation."

Singleton's legal saga began in 1979 when an Arkansas court convicted him of capital felony murder and aggravated robbery. His execution was originally scheduled to take place in June 1982.

Soon after the conviction, he petitioned the district court that tried him for a stay of execution on several grounds, one of which was that he was incompetent and thus ineligible for the death penalty in accord with the U.S. Supreme Court's 1986 decision in *Ford v. Wainwright*. That decision held that it is cruel and unusual punishment to execute a severely mentally ill inmate.

A series of appeals then followed in which his death penalty was changed to life without parole and then reinstated by the same appeals court that issued last month's ruling. In 1992 he petitioned to have his death sentence vacated because his mental illness—he has schizophrenia—rendered him incompetent. At the same time he asked to have his antipsychotic medication halted, after which he wanted a mental competency examination performed.

"Physicians violate their ethical obligations as healers when they treat condemned prisoners for the purpose of restoring competence to be executed."

Both the trial court and the Arkansas Supreme Court rejected his requests, and the death penalty was allowed to stand. He continued to take his medication voluntarily, which, he acknowledged, made him competent to understand what his fate was and why.

Five years after those decisions, he had stopped taking the medication voluntarily—with the consent of a prison psychiatrist, according to the decision—so Arkansas prison officials forced Singleton to take it, the appeals court decision notes, "after a medication review panel unanimously agreed that he posed a danger to himself and others." Once on the medications, his psychotic symptoms largely abated.

With his execution scheduled for March 1, 2000, Singleton filed a habeas corpus petition. He argued that in light of the Supreme Court's *Ford* decision saying it is unconstitutional to execute a mentally incompetent inmate, the state is prevented from forcibly restoring his mental competence by medicating him with antipsychotics. When the Arkansas courts rejected

please see ***Death Row*** *on page 50*

Association News

For Members Only

Please make a point of visiting the improved "Members Corner" area of APA's Web site soon and enjoy easier access. You no longer need your membership number to log in, and you can now select your own username. To access Members Corner, go to <www.psych.org> and click on "Members Corner Login" or go directly to <www.psych.org/login.cfm>.

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Advocating for Our Profession

BY PAUL APPELBAUM, M.D.

Fighting for the interests of the profession and our patients is APA's highest priority. In my last column, I told you about our Committee on Judicial Action, which manages APA's involvement in major legal cases, when we become involved as a "friend of the court." The briefs that we have submitted to the U.S. Supreme Court and other venues have had a major impact on the development of mental health law in this country.

When it comes to shaping policy relevant to psychiatry, of course, not all of the action takes place before a judge. The legislatures of the 50 states have a huge influence on the delivery of psychiatric services and the practice of psychiatry. Moreover, even when the courts are involved, our role as psychiatrists is not always limited to acting as a third party. Sometimes to make things happen, we need to initiate or join lawsuits as plaintiffs ourselves. Both lobbying in state capitals and filing legal actions, however, cost money—often a great deal of money—making funding a critical consideration.

Recognizing these additional advocacy needs for American psychiatry, APA's Board of Trustees established the Committee on Advocacy and Litigation Funding (CALF), a component of the Council on Advocacy and Public Policy. CALF, one of our most active components, is chaired by Jeffrey Janofsky, M.D., and meets regularly by conference call, and twice a year in person, to oversee APA's support for advocacy initiatives aimed at the states and the courts. A substantial sum of money, replenished each year, has been set aside by the Board for CALF's activities.

When it comes to funding advocacy efforts at the state level, CALF works closely with APA's district branches and state associations. Typically, a district branch submits a proposal to CALF for funding of a set of advocacy activities. Initiatives proposed by district branches may be focused on the development of advocacy infrastructure, for example, the creation of a statewide network of APA members who take responsibility for contacting their legislators about major issues of importance to the field. Often a serious effort is made to link up with other mental health advocacy groups, such as state affiliates of NAMI or NMHA, to form ongoing coalitions that can focus on issues related to the public's mental health.

Most frequently, though, the district branches that approach CALF have specific legislative targets that they want to pursue. The adoption of a mental health

please see ***From the President*** *on page 40*

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(PERKINS)
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SILVER HILL

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JANSSEN PHARMACEUTICA
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JANSSEN PHARMACEUTICA
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Bush Alters Medicare Plan After Bipartisan Criticism

Bipartisan criticism in Congress derails President Bush's efforts to change the Medicare and Medicaid programs even before he proposes formal legislation.

BY KATE MULLIGAN

President George W. Bush's anticipated plan to "reform" Medicare had not yet become a formal proposal before it was attacked by Democrats and some Republicans.

In his State of the Union address, Bush said, "Seniors happy with their current Medicare system should be able to keep their coverage the way it is. And just like you—the members of Congress—and other federal employees, all seniors should have the choice of a health care plan that provides prescription drugs."

Members of Congress and federal employees are covered by the Federal Employees Health Benefits Program (FEHBP), through which they select among competing health plans offered by insurance companies.

Congressional Democrats and some Republicans took Bush's second statement as a signal that he might propose restricting prescription drug benefits to Medicare beneficiaries willing to give up the current fee-for-service program for benefits administered through insurance companies.

On February 14, the *Washington Post* reported that even before a fully developed administration proposal was announced, several senior Republicans had criticized Bush's "anticipated suggestion" to provide prescription drug benefits only to Medicare beneficiaries who are willing to join insurance plans.

Sen. Charles Grassley (R-Iowa), chair of the Senate Finance Committee, and House Speaker J. Dennis Hastert (R-Ill.) have said the government must help all older people with the costs of prescription drugs.

According to the *Post*, Grassley said that the administration "botched" the development and announcement of its Medicare plan.

Thompson Denies Coercion

In a hearing before the House Energy and Commerce Committee on February 12, Tommy Thompson, secretary of Health and Human Services (HHS), responded repeatedly to concerns by committee members that persons on Medicare would be forced into managed care programs in order to receive prescription drug benefits.

He said, "There's not going to be any attempt to force seniors into HMOs in order to get prescription drugs."

Thompson, however, echoed Bush's implicit support for the FEHBP. He said, "[Participants] deserve more choice or at least the same choices as Congress and staff [get] through the FEHBP."

By early March Bush had retreated from an effort to restrict drug benefits only to people who enroll in Medicare managed care plans.

On March 3, the *New York Times* reported that Bush planned to propose making a prescription drug card available to all seniors and to offer a $600 subsidy to low-income participants for drug costs. Catastrophic coverage of an amount that had not been determined would also be available for all seniors.

According to the *Times*, Bush would offer "comprehensive coverage of prescription drugs and preventive services to people who join private insurance plans."

Both those who want greater involvement of private-sector health plans in the Medicare program and those who want to add a prescription drug benefit to the existing fee-for-service program cite Medicare+Choice (M+C) in their arguments.

The program was authorized by the Balanced Budget Act of 1997 with the intent of expanding health care services to Medicare beneficiaries by savings generated through what advocates assumed would be the efficiencies of managed care. Those savings were to be used to reduce premiums or offer benefits such as prescription drugs.

Beneficiaries could enroll in private plans, including health maintenance organizations, preferred provider organizations, and provider-sponsored organizations (*Psychiatric News*, December 21, 2001).

In a February 13 press release, Karen Ignagni, president and CEO of the American Association of Health Plans, said, "The facts show that Medicare+Choice plans today are delivering more and better coverage—including access to prescription drugs—than the fee-for-service program."

Problems in M+C Program

The "Fact Sheet on Medicare+Choice" published by the Kaiser Family Foundation in February, however, describes several problems.

Since 2000, M+C enrollment has declined by 27 percent to 11 percent of the Medicare population. Only 13 percent of those eligible living in rural areas have the option of enrolling in a M+C plan.

There has been a decline in availability and breadth of key benefits, particularly prescription drugs, while the percentage of beneficiaries who are charged premiums in addition to the monthly Part B premium has increased.

The evidence on quality of care and satisfaction is mixed, but several studies report problems for people with disabilities and those who want to access a specialist.

The government's General Accounting Office reported in August 2000 that Medicare "aggregate payments to Medicare+Choice plans in 1998 were about $5.2 billion (21 per-

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Be Prepared!

The compliance date for the federal privacy rule is just around the corner—April 14, 2003. To help APA members meet the compliance requirements, APA has developed a packet of educational materials and sample documents that can be accessed on APA's Web site at <www.psych.org/pub_pol_adv/hipaa/hipaa_guide.cfm>. Hard copies are available by calling the APA Answer Center at (888) 35-PSYCH.

The privacy rule was mandated by a subsection of the 1996 Health Insurance Portability and Accountability Act (HIPAA) titled "Administrative Simplification." This subsection required the creation of federal rules regarding the transmission and safeguarding of electronically shared health information. The packet includes the following materials:

- Frequently asked questions about the privacy rule
- Privacy rule policies and procedures
- APA's position statement on "Minimum Necessary Guidelines for Third-Party Payers for Psychiatric Treatment"
- Two resource documents: "Psychotherapy Notes Provision of the HIPAA Privacy Rule" and "Documentation of Psychotherapy by Psychiatrists"
- Three sample forms: "Notice of Privacy Practices," "Patients' Acknowledgment of Notice of Privacy Practices," and "Patients' Authorization to Use/Disclose Health Information"

The materials were developed by APA's Corresponding Committee on Confidentiality. The members of the committee are Margo Goldman, M.D. (chair), Douglas Ingram, M.D., David Benedek, M.D., Roxane Sanders, M.D., Arthur Farley, M.D., Joan Gerbasi, M.D., J.D., Peter Mayerson, M.D., Peter Ash, M.D., Latanya Sweeney, M.D., and Paul Mosher, M.D.

Goldman noted that members can use the committee's materials to draft policies and procedures that fit their particular practices. Nonetheless, they should still consult with an attorney to evaluate their specific circumstances and ensure that they comply with state law.

cent) more than if the plans' enrollees had received care in the traditional FFS program." It is "these excess payments and not managed care efficiencies" that enable M+C to offer more comprehensive benefits with small or no premium.

Edward Gordon, M.D., chair of APA's Medicare Advisory Corresponding Committee, told *Psychiatric News*, "Medicare+Choice failed to do the job of providing quality care and additional Medicare benefits through insurance companies. If enacted, Bush's effort to move from fee-for-service to a greater involvement of insurance companies would fail to help those on Medicare and represents a payoff to those companies."

Gordon said that in late February he met with Rep. Sue Kelly (R-N.Y.) as a member of her advisory committee on Medicare. She told the group that she supported a Medicare drug benefit that would be "minimally disruptive to seniors" and that Medicare beneficiaries should be able to stay in fee-for-service Medicare and still "access a drug benefit."

In related news, Thompson failed to secure the support of the National Governors Association (NGA) for the Bush administration's Medicaid proposal when the organization met in late February.

Under that proposal, states would have total flexibility in designing the benefits package and in determining beneficiaries for "optional" populations and services.

"Mandatory" populations and services must be covered for a state to participate in the Medicaid program. States determine what optional populations and services they will cover and receive federal matching Medicaid funds for them, as long as they adhere to certain guidelines.

In 1998 optional spending comprised 65 percent of total Medicaid spending and included such items as prescription drugs and case-management services.

At his January press conference announcing the proposal, Thompson said, "We can't get this legislation passed unless the governors are enthusiastically behind it and push it."

The governors expressed concern about the fact that funds would be "front-loaded" for seven years, with reductions in following years to compensate for those additional funds (*Psychiatric News*, March 7).

After disagreement between Republican and Democratic governors about the extent of financial help they would request from President Bush, the NGA passed a resolution asking the federal government for additional funds for three federally mandated programs: homeland security, special education, and the No Child Left Behind education bill. The NGA also separately requested funds to cover the cost of long-term care for people who qualify for both Medicare and Medicaid.

Bush turned down those requests, but offered to work with the states to reform Medicare and Medicaid.

On February 25 the NGA announced that it would seek financial assistance from Congress to help alleviate state budget crises.

"Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending" (HEHS-000161) is posted on the Web at <www.gao.gov>. Medicare fact sheets are available at <www.kff.org>. ■

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Mass. Governor Backs Off Threat To Slash Day-Treatment Programs

Massachusetts Psychiatric Society members and other advocates ward off a threat to mental health services, but a larger battle is looming.

BY KATE MULLIGAN

The Massachusetts Psychiatric Society (MPS) helped bring about a reprieve for the state's 40 psychiatric day-treatment programs.

Gov. Mitt Romney (R) had included the programs in a package of proposed Medicaid cuts designed to address the state's budget deficit of approximately $3 billion.

The proposed cut in the programs, which served 3,400 people in 2002, would have saved the state $1.1 million. According to Massachusetts Health and Human Services Secretary Ronald Preston, the governor changed his mind and spared the programs for one year as a result of the testimony of people with mental illness, their family members, and other advocates.

Preston told a *Boston Globe* reporter, "We have heard probably more about the psychiatric day-treatment program than any other cut. . . . What these people were saying is that they were living on the edge, and this was making a real difference."

Bruce Bird, Ph.D., chief executive officer of the North Suffolk Mental Health Association, told *Psychiatric News* that a coalition of nonprofit service agencies, people with mental illness and their families, and other mental health professionals had worked for several months to educate the press and state officials about the impact of the potential cuts.

He said, "During the critical period, more than 2,000 people a day were calling the governor's office to protest the cuts."

Advocates pointed out that cutting back on day treatment would result in increased costs for treatment in emergency rooms and in the number of homeless people.

Bird said that he and others recognize the need to document the efficacy of day-treatment programs and are working with research institutions to develop data that will substantiate their cost-effectiveness.

The North Suffolk Mental Health Association provides crisis, outpatient, community, and home-based services to residents of Boston and seven nearby communities.

Elizabeth Childs, M.D., president of MPS, testified in front of Preston and other state officials that "mental illness. . .is particularly devastating for patients and families without resources. . . . Removal of the safety net for these most vulnerable citizens and their families is catastrophic."

Growing Tally of Uninsured

Childs, who is director and chief of psychiatry at Carney Hospital in Dorchester, told the state officials that the number of uninsured is growing, "further burdening an uncompensated care pool, which has an estimated shortfall of $250 million."

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

David Matteodo, executive director of the Massachusetts Association of Behavioral Health Care Systems, told *Psychiatric News* that as of April 1 Massachusetts would eliminate Medicaid coverage for about 50,000 unemployed, low-income adults, which would expand the number of the uninsured and place further pressure on hospitals and other sources of inpatient care (*Psychiatric News*, February 7).

APA President Paul Appelbaum, M.D., told *Psychiatric News*, "States around the country are facing cuts in their Medicaid and mental health budgets that threaten devastating consequences for persons with mental illness. The Massachusetts experience demonstrates the value of reacting loudly and rapidly to such cuts and the importance of forming coalitions. It is not a foregone conclusion that people with mental illness must suffer disproportionately when times get tough."

Health Budget Cuts Likely

MPS and other mental health care advocates were gearing up for additional challenges at press time, when state officials were expected to release the proposed budget for Fiscal 2004. That budget will be implemented July 1. The governor also plans a reorganization of health and human services programs.

Childs told *Psychiatric News*, "We have to be realistic. We know there will be cuts across the entire spectrum of programs. But, she added, "We need to make certain that people with mental illness are not affected disproportionately. People on Medicaid don't complain and often don't have families to advocate for them."

Childs agreed with Appelbaum's assessment of the importance of coalitions. She said that MPS is working with other groups on a Mental Health Coalition Day on which psychiatrists and others will educate legislators about the impact of reorganization of state mental health programs and other issues.

State legislators are divided, according to Childs, about whether to try to increase various state taxes to deal with the budget deficit.

After President George W. Bush denied a request for financial assistance for federally mandated programs, the National Governors Association (NGA) refused to endorse his proposal for Medicaid "reform."

The NGA announced on February 25 that it would seek financial assistance from Congress to deal with state budget crises (see story on page 8). ■

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Quantity of Medical Care Doesn't Guarantee Quality

Because of dramatic regional variations in health care spending, people in some areas of the country receive 60 percent more care than people in others. Yet increased spending does not translate into better outcomes or satisfaction.

BY MARK MORAN

More medical care does not necessarily mean better medical care. That's what researchers at Dartmouth School of Medicine have concluded from a nationwide study looking at variation in spending, along with health outcomes and patient satisfaction. Their report, "The Implications of Regional Variations in Medicare Spending," appears in the February 18 *Annals of Internal Medicine*.

Lead author Elliott S. Fisher, M.D., told *Psychiatric News* that the study confirms many previous reports demonstrating wide variation in health care utilization and spending from region to region and within states.

"We have known for 30 years that there are big differences across regions and in neighboring communities in the amount of care provided to similar populations," Fisher said. "What we haven't known is what this means in terms of outcome for those who are receiving less or more."

He is co-director of the Veterans Administration Outcome Group and professor of medicine at Dartmouth School of Medicine.

What Fisher and colleagues found would appear to turn conventional wisdom on its head: people in higher-spending regions received approximately 60 percent more care than those in other regions, but this increased medical care did not result in better satisfaction or health outcomes.

"It contradicts the general assumption that more medical care means better medical care," Fisher told *Psychiatric News*.

In the study, Fisher and colleagues looked at care of Medicare patients hospitalized from 1993 to 1995 for hip fracture, colorectal cancer, or myocardial infarction, and of a representative sample drawn from the Medicare Current Beneficiary Survey.

They examined the frequency and type of services received, quality of care based on recommended best practices—such as whether patients received flu vaccine or were given aspirin after a heart attack—and access to care.

The average baseline health status of the cohort was similar across regions of differing spending levels, but patients in higher-spending regions received 60 percent more care.

The researchers were able to compare the actual amount of care being provided in different regions, independent of the variation in cost services from region to region. They did this by using the End-of-Life Expenditure Index, a measure reflecting the regional-variation component in Medicare that is due to physician practice rather than regional differences in illness or price.

Fisher reports that the increased utilization in higher spending regions is attributable to more frequent physician visits, especially in the inpatient setting, more frequent tests and minor procedures, and increased use of specialists and hospitals.

"What we see is that in the higher-spending regions, the additional services are almost entirely discretionary," Fisher said.

Higher-spending regions also had more frequent psychotherapy visits—nearly three times more than other regions. "Our hypothesis is that there are more therapists in those regions," Fisher said. "The higher-spending regions are those that typically have more specialists."

But APA Vice President Steven Sharfstein, M.D., an expert in health care economics, said the continuing discriminatory coverage of mental illness—in both the Medicare and private pay markets—makes it difficult to apply the study's lessons to psychiatry.

"It has been well known for a long time that the supply of medical and psychiatric care has an important influence on the cost of care," Sharfstein said. "But the major problem for psychiatry is the continuing discriminatory coverage under Medicare."

Sharfstein cited the 50 percent copayment for psychiatric care—in contrast to 20 percent for medicine—and the 190-day lifetime limit for psychiatric hospitalization as particular burdens for those who are seriously and persistently mentally ill.

"Underinsurance for psychiatric care remains the number one public policy issue for our patients today," he said.

Yet quality of care in the regions where people received more care was no better on most measures. For instance, patients were no more likely to receive aspirin after a heart attack or receive a beta-blocker upon discharge, or to receive flu and pneumonia vaccines.

High technology, end-of-life care is often assumed to drive health care spending, but Fisher said that people in the regions where people received more care did not necessarily receive more major procedures—such as bone marrow transplants and bypass surgeries—to extend life.

"What we do see is much more aggressive use of the intensive care unit and a greater likelihood for the use of feeding tubes and intubation," Fisher said.

Again, the regions where people received more care did not see a gain in survival. Remarkably, Fisher said the study found a 2 percent to 5 percent higher increased risk

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Volkow to Head Federal Addiction Research Agency

The National Institute on Drug Abuse has tapped one of the addictions field's most respected researchers as its next director.

BY JIM ROSACK

Noted substance abuse researcher Nora D. Volkow, M.D., currently associate director for life sciences at the Brookhaven National Laboratory, has been named by National Institutes of Health Director Elias Zerhouni, M.D., as the next director of the National Institute on Drug Abuse (NIDA).

Volkow, an APA member, is also director of nuclear medicine and director of the NIDA–Department of Energy Regional Neuroimaging Center at Brookhaven. In addition, she is a professor of psychiatry and associate dean at the State University of New York–Stony Brook School of Medicine.

Volkow is expected to begin her duties at NIDA in mid-April. She replaces Glen R. Hanson, D.D.S., Ph.D., who has served as acting director since the departure of Alan Leshner, Ph.D., in December 2001. Leshner left NIDA to become chief operating officer of the American Association for the Advancement of Science.

"Dr. Volkow's experience as a NIDA-funded researcher puts her in a unique position to lead the institute into the future," Zerhouni said in announcing the appointment. "She will bring the full power of science to confront the critical issues of drug abuse and addiction."

Nora D. Volkow, M.D., is the new head of the National Institute on Drug Abuse.

In a prepared statement, Volkow said she looked forward to the "opportunity to help fight one of the most serious problems facing our society—that of drug addiction."

Volkow is noted for her work on the brain's dopamine system and, in particular, recently completed studies that have shed significant light on how the dopamine system responds to stimulants such as methylphenidate, methamphetamine, and cocaine (*Psychiatric News*, September 21, 2001; January 18, 2002).

Applauding the appointment, Secretary of Health and Human Services Tommy Thompson said, "I'm happy that Dr. Volkow accepted this important position to help expand scientific research and share NIDA results with health practitioners and the public."

Volkow has written or cowritten more than 275 peer-reviewed articles and edited three books and more than 50 book chapters. She was elected to the Institute of Medicine's National Academy of Sciences and was named "Innovator of the Year" in 2000 by *U.S. News and World Report*. ■

Residents Chosen for APA/Shire Fellowship

This fellowship addresses the shortage of child and adolescent psychiatry by exposing residents to the field.

The APA/Shire Child and Adolescent Psychiatry Fellowships have been awarded to four residents for 2003-04. The recipients are R. Gregg Dwyer, M.D., Ed.D., of the University of South Carolina School of Medicine; Niranjan Karnik, M.D., Ph.D., of the department of psychiatry and behavioral sciences at Stanford University Medical Center; Robyn L. Ostrander, M.D., of Dartmouth-Hitchcock Medical Center; and William Wood, M.D., of Massachusetts General and McLean hospitals. They were selected from 43 applicants.

The APA/Shire Child and Adolescent Psychiatry Fellowship is designed to address some of the particular concerns and generate interest in work with children and adolescents. APA believes it is imperative to expose residents to the most exciting new clinical research and the most successful public programs for the treatment of seriously mentally ill children and adolescents.

The two-year fellowship includes travel and meeting expenses to two APA annual meetings and work with mentors on specific issues in child and adolescent psychiatry. At these meetings, the fellows will have opportunities to meet and network with leaders in child and adolescent psychiatry. They will be matched with mentors who will consult with them about items on the program of special interest. In addition, they will meet as a group to talk about the meeting presentations.

For the second year of the fellowship, each fellow will submit a proposal to the APA Scientific Program Committee for a workshop on a topic in child and adolescent psychiatry to be given at the 2004 annual meeting, which will be held in New York City from May 1 to 6.

The fellowship is supported by an unrestricted educational grant from Shire Pharmaceuticals. It is overseen by the APA Council on Children, Adolescents, and Their Families and administered by the project manager of the Office of Children's Affairs. ■

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CDC To Fund Major Study Of ADHD Risks, Treatment

A new initiative involving three study sites will help researchers increase their knowledge about ADHD.

BY MARK MORAN

The National Center on Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention (CDC) is funding what appears to be the largest community-based epidemiologic study of attention-deficit/hyperactivity disorder (ADHD).

Catherine Lesesne, M.P.H., a behavioral scientist at the center, said that the research will focus on the prevalence and treated prevalence of ADHD in children, the existence of comorbid and secondary conditions in children with ADHD, the types and rates of health risk behaviors in children with ADHD, and current and previous treatment patterns for children with ADHD.

Lesesne said three sites will be funded with $250,000 each. They are the University of South Carolina (principal investigator, Robert E. McKeown, Ph.D.); the University of Oklahoma Health Sciences Center (principal investigator, Mark L. Wolraich, M.D.); and Eastern Virginia Medical School (principal investigator, Gretchen B. LeFever, Ph.D.).

"We are looking for the researchers to provide screening in a school-based setting for at least 5,000 children," Lesesne told *Psychiatric News*. Ideally, she said, the goal is to obtain prevalence rates for children aged 4 to 10, though 4-year-olds may be harder to find if they are not yet in the school system.

A somewhat novel aspect will be an attempt to describe health-risk behaviors in children with ADHD, such as sleep behavior, truancy, smoking, bullying, or fighting. "Ultimately, we want to better describe in a community sample the types of risk behaviors and try to understand what impact those might have in the long term," Lesesne said.

Lesesne said that the CDC began looking at the public health implications of ADHD in 1998 and held a conference in 1999 on the subject. It was there that a research agenda was outlined that forms the basis for the new grants.

Part of that agenda included developing a mechanism for public dissemination of health education information about ADHD. In keeping with that goal, the center has since been able to provide $750,000 to Children and Adults With Attention-Deficit/Hyperactivity Disorder (CHADD), a nonprofit support group, to develop a national resource center for disseminating public information.

"We were able to fund CHADD to improve its ability to serve this educational purpose," Lesesne said. "CHADD will now be operating a live call-in center and be working to disseminate accurate and valid information about ADHD."

"This is a monumental development in CHADD's history and a significant milestone in recognizing the challenges faced by persons with ADHD," said E. Clarke Ross, chief executive officer of CHADD. "The national government's leading public health agency has declared that ADHD is not only a valid disorder, but is significant and serious enough to warrant a national resource center for obtaining and disseminating science-based research and information."

More information about CHADD is posted on the Web at <www.chadd.org>. ■

Quantity

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of death in regions that provide more care.

Can the findings reasonably be applied to the private-pay population?

Fisher believes so. "Medicare practice patterns are highly correlated with practice patterns for the care of those under 65," he said.

If so, reduction in variation and adoption of conservative practice patterns typical of lower-spending regions would have enormous consequences for the nation's health care system.

"It suggests that 30 percent of all spending is at stake, and potentially we could be saving up to $400 billion a year if we could practice more conservatively," Fisher said.

The barriers to achieving such savings are significant, he added. Principal among them is the pervasive cultural belief that more care means better care. "The press and commercial messages from the drug and device industries all strongly reinforce the notion that more medical care means better care," Fisher said.

Moreover, incentives to provide more care—rather than more efficient or better-quality care—are built into reimbursement structures. "We currently pay physicians and hospitals to provide more care, not to provide better care," Fisher said. "So any solution will require rethinking the financial incentives built into the system."

In the meantime, Fisher said the findings suggest at least some directions the health care system should avoid. "We should not be thinking about increasing the number of specialists or increasing spending on health care," Fisher said.

An abstract of "Implications of Regional Variations in Medicare Spending" is posted on the Web at <www.annals.org/issues/v138n4/abs/200302180-00006.html>. ■

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More Patients Treated By Multiple Clinicians

More Americans are now getting "conjoint care," that is, they see both physician and nonphysician clinicians for chronic conditions.

BY MARK MORAN

American health care appears to be no longer the exclusive province of physicians, but of a wide range of physician and nonphysician clinicians providing "conjoint" care to patients with a variety of chronic conditions.

But whether that phenomenon of patients seeing multiple physician and nonphysician practitioners for the same condition reflects the kind of cooperative, coordinated, multidisciplinary care envisioned by "progressive" managed care—or whether it reflects competitive "parallel play" in an already fragmented system—is not clear.

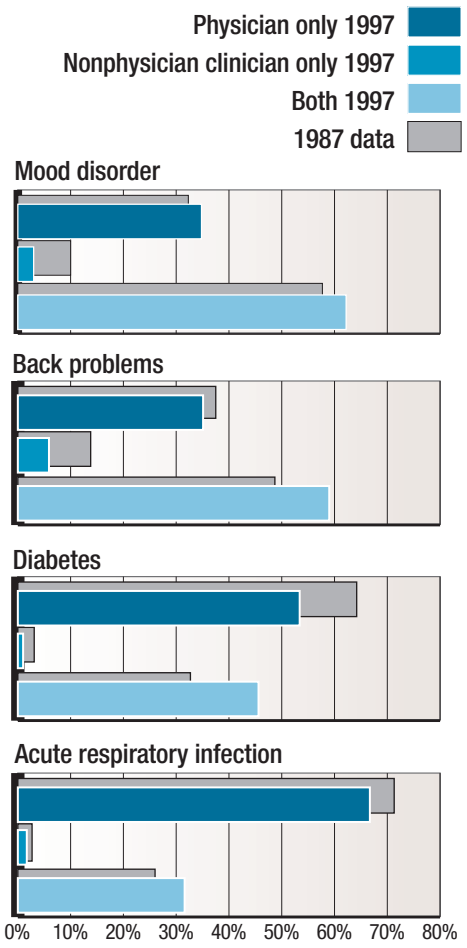
"This conjoint care may represent the kind of coordinated, multidisciplinary care that is the state-of-the-art management for patients with chronic conditions," psychiatrist Benjamin Druss, M.D., told *Psychiatric News*. "In other cases, it may represent the same patient seeing multiple providers who are not communicating effectively or who are working at cross purposes. Certainly, there have been a lot of forces that have been creating incentives for different kinds of providers to work together. But many of the same forces are also often creating a system that is very hard to navigate. In all likelihood, these are not mutually exclusive. Patients are seeing more providers for the right reason and in some cases for the wrong reason."

Druss is the Rosalynn Carter Chair in Mental Health at Emory University School of Medicine in Atlanta.

"More patients are getting their health care from more providers with different kinds of training and different philosophical orientations," Druss and his colleagues wrote in the January 9 *New England Journal of Medicine*.

Druss and his colleagues found that between 1987 and 1997 the proportion of patients who saw a nonphysician clinician rose from 30.6 percent to 36.1 percent. This trend was driven by an increase in the proportion of people who visited both a physician and a nonphysician, rather than an increase in the proportion who saw only a nonphysician clinician.

Conjoint Care Mix Varies by Condition



Source: Benjamin G. Druss, M.D., M.P.H., et al., *New England Journal of Medicine*, January 2003

Of eight chronic conditions the authors studied, mood disorder was the one for which patients were most likely to see both a physician and a nonphysician, and the least likely to see a physician only. This was true in both 1987 and 1997, according to the report.

Yet for all of the conditions there was an increase in conjoint care between 1987 and 1997—and in some a fairly substantial increase. For instance, the percentage of patients who used both physician and nonphysician practitioners for care of a normal pregnancy grew from 27.4 percent in 1987 to 41.7 percent in 1997. And the percentage of patients receiving conjoint care for arthropathy grew from 37.9 percent in 1987 to 51.1 percent in 1997. (The percentage of patients receiving conjoint care for mood disorders was 57.7 percent in 1987 and 62.2 percent in 1997.) The other conditions studied were "back problems," acute respiratory infection, eye disorder, essential hypertension, and diabetes.

Druss said the phenomenon suggests that the possibilities and pitfalls of conjoint care are shared across medical specialties and are not unique to any one specialty.

"We became interested in this because of the importance of these issues for mental health quality and in terms of workforce issues for providers," Druss told *Psychiatric News*. "But what we realized as we began to explore this in greater depth is that there are more similarities than differences in these issues across medical specialties. The opportunities and anxieties faced by psychia-

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trists as they look at their nonphysician providers are far more similar to, rather than different from, those faced by other specialists."

Co-author Harold Pincus, M.D., agreed that the phenomenon of conjoint care reflects—for good or for ill—a significant transformation in the provision of care for chronic conditions throughout medicine.

"The world has changed," said Pincus,

"More patients are getting their health care from more providers with different kinds of training and different philosophical orientations."

who is a professor and executive vice chair of the department of psychiatry at the University of Pittsburgh School of Medicine. "There really does seem to be a shift in how care is being delivered. What we don't know is what the outcome is for patients."

Pincus and Druss said the *NEJM* study documents the phenomenon of conjoint care, but it does not look at what is happening—or not happening—between physicians and nonphysicians as they provide care to the same chronically ill patients. That will be the focus of future research, they said.

"We don't know a lot about the specific content of care that is being delivered across these different provider groups," Druss said. "We are going to look at prescribing patterns by midlevel clinicians and how those are influenced by scope-of-practice laws and managed care, and also try to understand as much as possible the differences in quality of care for depression between physicians and nonphysician clinicians."

Druss said he believes, on the basis of anecdotal experience, that the relationships between psychiatrists and nonmedical clinicians treating the same patient are generally good. It is at the professional organizational level that competitive issues become heated and politicized, particularly around the issue of prescribing. "Prescrib-

Please see ***Conjoint Care*** *on page 17*

Primary-Care Models to Be Developed

To increase the use of effective models for treating depression in primary care settings, the Robert Wood Johnson Foundation is funding the five-year, $12 million program "Depression in Primary Care: Linking Clinical and System Strategies."

National program director Harold Alan Pincus, M.D., explained that depression is commonly encountered in primary care patients, but it may go undetected or untreated due to barriers at the level of both the clinician and the health system.

"We know that depression is a serious and chronic illness that should be conceptualized no differently from any other chronic illness," Pincus said. "We also know what works to improve care, but it is not being implemented because of barriers at multiple levels. The way to overcome those barriers is by working at these multiple levels."

Pincus said that putting these models into place will require a combination of clinical and economic and system strategies at multiple levels, engaging patients, providers, practices, plans, and purchasers.

"A lot of the disconnectedness between physicians and nonphysicians, between HMOs and carveouts, and between behavioral health and general health has a lot to do with perverse incentives built into the system," Pincus said.

More information about the program is posted at <www.wpic.pitt.edu/dppc>.

TV Plots Examine Plight Of Uninsured

Television shows turn their cameras on the problems endured by Americans who have no health insurance.

NBC's "Passions" and "Law and Order: Special Victims Unit" and Lifetime's "Strong Medicine" are among the television shows that have incorporated story lines about the serious problems confronting people without health insurance.

The plot lines were part of "Cover the Uninsured Week," an initiative by the Robert Wood Johnson Foundation to draw attention to the 41 million people nationwide who have no health insurance.

It took place March 10 through March 16.

Stuart Schear, campaign head for the foundation, said, "We know a lot of Americans get their information not only from Brokaw and Rather, but also from daytime soap operas and nighttime dramas."

AARP, the American Medical Association, and the AFL-CIO cosponsored the campaign, which featured more than 500 events such as town-hall meetings and forums about issues related to lack of health insurance coverage.

In related news, the *Christian Science Monitor* on March 4 reported that many employers were increasing health insurance premiums so much that workers could not afford them, and an increasing number of small and medium-sized companies were dropping health insurance altogether.

In the next year, more than 2 million people will lose the health insurance coverage they now have, according to the *Monitor*. ■

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Residents Try to Impact Federal Legislative Process

Two psychiatry residents are learning that their interest in health policy and issues that affect people with mental illness can make a difference.

BY BARBARA MATOS

They may be only at the start of their careers in psychiatry, but two young residents are showing legislators on Capitol Hill just how far their burgeoning passion and dedication can take them when it comes to standing up for the rights of Americans with mental illness and others needing access to health care.

The residents—Michael D. Barnett, M.D., and Andrew J. Kolodny, M.D.—made the trek to the Hill by way of the American Psychiatric Foundation's Daniel X. Freedman Congressional Fellowship. The fellowship began in January and wraps up in June.

Michael D. Barnett, M.D., works in the office of Rep. Patrick Kennedy (D-R.I.).

Andrew J. Kolodny, M.D., works in the office of Sen. Joseph Lieberman (D-Conn.).

Barnett is working in the office of Rep. Patrick Kennedy (D-R.I.). He is a graduate of New York Medical College and a resident at the George Washington University Hospital in Washington, D.C.

"The amount I have learned in a mere few weeks on the job is enormous," he told *Psychiatric News*. "Being able to be politically active on behalf of psychiatry and having a chance to work with congressional and senatorial offices on the mental health parity bill that's being named in honor of the late Sen. Paul Wellstone is an incredible honor to me." That bill was introduced in the Senate in January (see page 1).

Kolodny is working in the office of Sen. Joseph Lieberman (D-Conn.). He is a graduate of Temple University School of Medicine and a resident at the Mount Sinai School of Medicine in New York.

Kolodny also said that he appreciates the opportunity that the Freedman fellowship is giving him to learn about the development of health policy at the federal level.

"My primary responsibility is to advise Sen. Lieberman on health care legislation. I've been invited to numerous briefings and conferences on Medicare reform, Medicaid, prescription drugs, and the uninsured. In addition, I've had the privilege of meeting with many of the nation's foremost experts on health policy, as well as many constituents who have described firsthand the effects of the health care crisis our country is facing."

If timing is everything, then Kolodny hit the jackpot. With Lieberman's recent announcement that he intends to make a presidential bid, Kolodny said that the atmosphere in the senator's office is particularly exciting and intense. "Staff members joked that they could all benefit from having a psychiatrist in the office," he said.

Both Barnett and Kolodny strongly advise other psychiatry residents interested in advocating for people with mental illness and the profession of psychiatry to apply for the Freedman fellowship.

"It is a unique, once-in-a-lifetime opportunity," said Barnett.

The fellowship is supported by Eli Lilly and Company and the American Psychiatric Foundation. More information is available by contacting Matos at bmatos@psych.org. ■

Ms. Matos is administrative director of the American Psychiatric Foundation Inc.

Resignation

Martin H. Stein, M.D., of Washington, D.C., resigned from the American Psychiatric Association and from the Washington Psychiatric Society during the course of an ethics investigation. APA's "Procedures for Handling Complaints of Unethical Conduct" requires that resignations that occur during the course of an ethics investigation be reported in *Psychiatric News*. ■

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Election Results

continued from page 1

is currently APA's secretary, and Clemens is the Area 4 trustee.

Two former speakers of the APA Assembly faced off in the race for secretary. Nada Stotland, M.D., of Chicago prevailed with 63.1 percent of the vote, defeating Al Herzog, M.D., of Hartford, Conn.

Tanya Anderson, M.D., of Chicago won the seat on the Board of Trustees for ECP (early career psychiatrist) trustee-at-large. She defeated Charles Price, M.D., of Reno, Nev., with 61.6 of the vote.

The race for member-in-training trustee-elect had three candidates this year, with Susan Rich, M.D., of Georgetown University Hospital in Washington, D.C., emerging as the winner. Taking 51 percent of the votes cast on the first round of counting, she defeated Christopher (Drew) Ramsey, M.D., of New York Presbyterian Hospital/New York State Psychiatric Institute in New York City, and William C. Wood, M.D., of McLean Hospital in Belmont, Mass. Wood came in second, with 30.5 percent of the vote.

Three of APA's seven Areas elected a trustee this year. Donna Norris, M.D., of Wellesley, Mass., was chosen Area 1 trustee over Jack Brandes, M.D., of Toronto. She garnered 65.5 percent of the vote.

Sidney Weissman, M.D., of Chicago emerged as the victor in the race for Area 4 trustee with 56 percent of the vote. He defeated Michael Pearce, M.D., of Indianapolis.

Incumbent Al Vogel, M.D., of Albuquerque defeated Nady El-Guebaly, M.D., of Calgary, Alberta, for Area 7 trustee. Vogel had 68.2 percent of the vote.

The tenure of the newly elected Board members begins at the close of APA's 2003 annual meeting in May. At that time the current president-elect, Marcia Goin, M.D., will become APA president.

APA members also passed an amendment to the Association's Bylaws reducing the size of the Board of Trustees by two positions and adding the immediate past president to the Executive Committee.

As currently constituted, the Board has 21 voting members. Beginning with the 2004 election, one of the vice-president positions will be eliminated. The first member to serve as secretary-treasurer will be nominated for treasurer in 2003, elected in 2004, and become secretary-treasurer in 2005, at the conclusion of the last secretary's term. The first members to run for the position of secretary-treasurer will be nominated in 2005 for APA's 2006 election.

The addition of the immediate past president to the Executive Committee in 2003 brings its membership total to nine. However, effective in May 2005, when the transition to the Board's new composition is complete, the Executive Committee will have seven members: the president, president-elect, vice president, secretary-treasurer, speaker of the Assembly, and the immediate past president, who are voting members, and the medical director, who is not a voting member.

The amendment passed by an overwhelming majority, with 92.6 percent of the voters supporting it.

This year, there were 30,206 eligible voting members. Of that number, 33.9 percent, or 10,252, voted.

Detailed election results appear in the chart below. ■

Become an APA Fellow!

Fellow status is an honor that reflects your dedication to the work of APA and signifies your allegiance to the psychiatric profession. Complete information and application materials are posted on APA's Web site at <www.psych.org/apa_members/applyfellow.cfm>.

Conjoint Care

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ing is the bright line," he said.

He said most states allow some prescribing by "midlevel" practitioners with regulations and under physician supervision. "No one understands how frequently this occurs or what the implications are for the patient," he said.

Pincus said a five-year, $12 million program funded by the Robert Wood Johnson Foundation—Depression in Primary Care: Linking Clinical and System Strategies—is looking at how to implement clinical and health system strategies to achieve optimal outcomes for patients with depression (see box on page 15).

But Druss said there is at least indirect evidence from the *NEJM* study that some, if not all, of the conjoint care being delivered may be conforming to the prescribed vision of coordinated, collaborative health care. For instance, more nonphysician clinicians appear to be practicing with a physician on site, implying at least the opportunity for collaboration across disciplines, Druss reported.

In addition, he said that those nonphysician clinicians tend to be treating sicker patients, but providing preventive care rather than acute medical care—again suggestive of the practices envisioned in a model of coordinated care for chronic conditions.

For psychiatrists, as for other medical specialists treating chronic conditions, the message would appear to be that conjoint care is a reality not likely to go away. "It is increasingly likely that psychiatrists' patients will be treated by other physicians and also by other nonphysician clinicians," Druss said. "It is a responsibility of clinicians, patients, and health systems to see that the care that is being delivered is well-coordinated and of high quality."

An abstract of the study, "Trends in Care by Nonphysician Clinicians in the United States." is posted on the Web at <http://content.nejm.org/cgi/content/abstract/348/2/130>. ■

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APA Brings Grand Rounds To Your Computer

An innovative APA program uses e-mail technology to provide members a forum for networking with colleagues about topics of professional interest while earning CME credits.

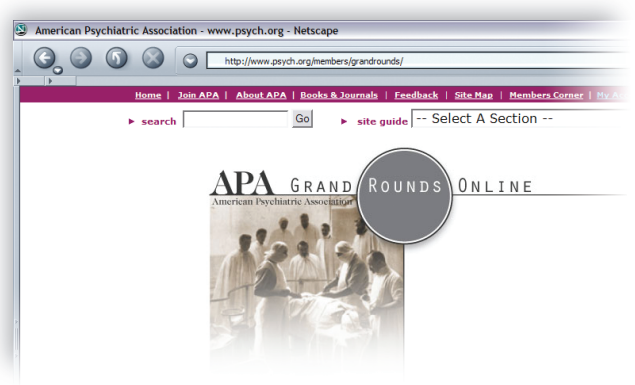
BY MARK MORAN

Getting continuing medical education (CME) credits can be as easy as turning on your computer and opening your e-mail.

And it might just turn out to be a more memorable experience than the run-of-the-mill conference or symposium, say psychiatrists who have participated in APA's new free CME service, Grand Rounds Online.

Deborah Hales, M.D., director of APA's Division of Education, Minority, and National Affairs, told *Psychiatric News* that Grand Rounds Online capitalizes on e-mail technology to provide a convenient venue for discussing important professional topics with APA members—while picking up CME credits.

"We are interested in developing new ways to offer psychiatrists continuing education," Hales said. "I am a fan of e-mail, and since e-mail is ubiquitous now, we decided that a list-serve-based discussion of professional topics would be a low-cost way to offer educational programs to members."



APA introduces Grand Rounds Online, bringing a traditional teaching concept to the Internet age.

Members who wish to participate will need to sign onto Grand Rounds Online at <www.psych.org/members/grandrounds> with a username and password. Once signed in, they will find one or more case discussions being presented by a moderator with expertise in the subject. The case is likely to be drawn from real clinical experience, highlighting important aspects of the subject for discussion.

Members choose a topic they are interested in and join the list serve. Then all pertinent comments by the moderator and other participants will be sent regularly to each participant's e-mail address. Members can add their own thoughts on the case or respond to comments by others on the list serve.

Occasional Quizzes Included

Active discussion of a case lasts a month, at which point all cases go into an archive where they are accessible for one year. At the end of the active month, a quiz is posted on the APA Web site; members answer the questions, press "submit," and receive two hours of CME credit. The certificate arrives via e-mail.

It's free and it's user friendly. "All you need is a computer and to know how to use e-mail," Hales said.

A look at either of the two cases already posted on Grand Rounds Online reveals that "discussions" are liable to be more lively than what typically occurs in a crowded conference symposium.

"It was very interactive," said Miles Shore, M.D., who moderated a case discussion on patient safety. "It gets people engaged. I didn't count up the responses, but I would say that people who responded tended to be very involved in the subject matter."

Anthony Ng, M.D., who led a discussion on disaster psychiatry, agreed. "It's a great way for people to connect with colleagues who may or may not be doing the same thing," he said. "It promotes networking and provides a forum for discussion about topics that people don't typically have any input into."

School Shootings Discussed

Ng, who is a member of APA's Committee on Disaster Psychiatry, moderated discussion of a case describing a school shooting. He said the discussion took on a special poignancy since it was active around the time of the sniper shootings in the Washington, D.C., area.

He is also medical director of Disaster Psychiatry Outreach, a national nonprofit group based in New York.

Shore, who is a professor of psychiatry at Harvard Medical School, moderated discussion of a case of a man presumed to be homeless; he was brought to the emergency room of a large teaching hospital and placed on a standard detoxification protocol. Only later was it learned that the man had multiple fractures and had been hit by a car.

Shore said his goal in discussing the case was to move participants away from "the guilt culture"—whereby individual physicians are held accountable and punished for oversights—toward a "culture of error prevention" in which the focus is on protocols

please see ***Grand Rounds*** *on page 40*

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Mental Health Courts Better, But Still Need Work

The federal government continues to fund more mental health courts to divert people with mental illness into treatment and away from jail. A recent report offers a snapshot of how these courts operate and recommends reforms.

BY CHRISTINE LEHMANN

About 30 American communities have established mental health courts to offer people with mental illness a treatment alternative to jail or prison.

While everyone agrees that jails and prisons are not therapeutic environments, the results of a survey presented in a new report show that mental health courts carry their own risks.

The report, "The Role of Mental Health Courts in System Reform," was released in January by the Bazelon Center for Mental Health Law, a mental health advocacy organization in Washington, D.C.

Mental health courts have a separate docket with a judge, prosecutors, and defense attorneys who have some training to deal with defendants with mental illness. Treatment plans are drawn up in conjunction with community mental health professionals. Defendants live in community settings and may have their charges dropped when they complete treatment.

The Bazelon Center authors conclude from a survey conducted last year of 20 mental health courts that some use "coercive tactics similar to the controversial intervention outpatient commitment."

Co-author Tammy Seltzer told *Psychiatric News*, "People with mental illnesses should be aware of the conditions imposed by mental health courts in exchange for treatment. About 50 percent of the courts surveyed required a guilty plea, which waived the defendant's right to a trial. About 40 percent reported that the defendant was supervised by the court far longer while in treatment than possible jail or prison time [they would have gotten] for a similar offense."

The report criticizes the use of guilty pleas because "they add a conviction to the person's record, which impedes the individual's ability to obtain and maintain housing and employment, which is so necessary for long-term mental health treatment, community tenure, and management of a long-term psychiatric disability."

In addition, "If a defendant without a mental illness would typically have the charges dismissed, it is discriminatory to require a person with a mental illness to plead guilty to access services and supports."

Punishment for Noncompliance

Only 30 percent of the courts surveyed dismissed the defendants' charges once they successfully completed treatment. The authors said that all courts should dismiss charges upon treatment completion.

About 64 percent of the mental health courts used jail time as a sanction for noncompliance, and 18 percent reported they might drop the individual from the treatment program for noncompliance, the report notes.

Defendants who decide not to complete the prescribed mental health court treatment should be allowed to "withdraw without prejudice." This means withdrawing their guilty plea or being able to contest it at trial, explained Seltzer. However, 56 percent of the courts surveyed prohibited this, and one court allowed the judge to impose a harsher sentence if the defendant didn't complete mental health treatment, said Seltzer.

"These actions are particularly unhelpful if the issue is one of normal relapse and the ups and downs of recovery from mental illness," the authors wrote.

They recommended that a defense attorney be appointed for a person identified as a mental health court candidate when charges are pressed. The attorney should explain all options to resolve the case to the defendant and the consequences of a transfer to mental health court.

Who Gets Access?

Mental health courts traditionally have limited access to people with mental illness who commit misdemeanor and nonviolent felonies. Although 80 percent of the courts reported that they consider cases involving violent acts, 40 percent of those required a special process before accepting those cases, for example a victim's consent or a review of specific charges, according to the report.

"We would like to see all mental health courts serve people who commit serious felonies, excluding murder. Most traditional courts already have mechanisms to divert people charged with misdemeanors including alternative sentencing and pretrial diversion to treatment," said Seltzer. "We believe those options should be made available to all defendants regardless of their mental health status."

The authors also recommended collaboration between mental health professionals and police officers to identify people with mental illness charged with "nuisance" misdemeanors such as disturbing the peace or trespassing. This would result in fewer arrests and incarceration.

Mark Munetz, M.D., chief clinical officer of the Summit County Alcohol, Drug, Addictions, and Mental Health Services Board in Akron, Ohio, said, "Our municipal mental health court serves only people with misdemeanors. I would hate to see them have access only to traditional court diversion options, which we found results

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legal news

Small Town Confronts Big Discrimination Penalty

In a potentially precedent-setting case, a town pays substantial damages after it loses its legal battle to keep a psychiatric rehabilitation facility from opening.

BY KEN HAUSMAN

Leonardtown, in southern Maryland, may be a typical small town, but it is facing a legal bill that is anything but typical since it denied a psychiatric rehabilitation facility the right to open within its borders.

In the settlement of a lawsuit that began in 1999—and in which a jury had already found the town at fault—Leonardtown agreed to pay $825,000 to Pathways, a nonprofit organization that serves people with psychiatric disabilities. The town also agreed to establish an award for a person or organization that makes significant contributions to bettering the lot of people with psychiatric disabilities.

In 1997 Pathways was a program with a single facility in an isolated, rural area of St. Mary's County. Its directors decided to build a new facility in the county seat, Leonardtown, to make it easier for them to integrate their clients into the community (*Psychiatric News*, February 1, 2002). The program serves about 35 to 40 clients a day.

Pathways had located a parcel in a downtown area for which town officials were encouraging development and property purchasers qualified for financial assistance under a state program that fosters redevelopment in rundown areas.

Leonardtown officials and town council member Daniel Muchow, however, took several steps to ensure that Pathways' zoning application met a dead end. Two months after the council approved the new building, Muchow reopened the issue by raising alarms about the prospect of having dozens of mentally ill people in the heart of Leonardtown. He and several citizens convinced the council to revoke its endorsement. As a result, Pathways lost its opportunity for state funds.

Pathways next strategy was to locate another in-town building lot and use borrowed, private funds to construct its new facility. The council's counterstrategy, however, was to use zoning laws to reject an occupancy permit. It claimed that there was inadequate parking for the number of people the center planned to serve and that a rehabilitation facility had no place in a part of town zoned for commercial enterprises. It does, however, allow medical offices to operate there.

Pathways, along with one of its clients, Clarissa Edwards, then turned to the courts, claiming that the town's actions put it in violation of the Americans With Disabilities Act. The court agreed that disability discrimination was a legitimate issue to raise in this case and allowed the suit to go to trial.

In December 2001 a federal district court jury found in favor of Pathways and ordered the town to pay it more than $540,000 and Edwards $20,000 in compensatory damages stemming from its lost opportunities to purchase the two lots and build on them. Muchow was ordered to pay Pathways $1 in compensatory damages and $5,000 in punitive damages and to pay Edwards $1 in compensatory damages and $15,000 in punitive ones.

Leonardtown responded to the verdict by appealing to the trial judge to set aside the verdict, insisting that it "does not, individually or collectively, discriminate against the mentally ill." The judge refused to do so.

After that ruling, the town filed a notice to appeal with the Fourth Circuit Court of Appeals. At the same time, Pathways and Edwards filed a motion for reimbursement of attorney fees and court costs.

Realizing that the tally would exceed the jury's damage awards if it was assessed these fees and costs, Leonardtown indicated that it was willing to try to arrive at a negotiated settlement with Pathways.

In the settlement reached in February, Leonardtown will have to pay Pathways $825,000, which includes its legal fees, and the town agreed to implement as-yet-unspecified initiatives to benefit residents with disabilities. In addition, the town's insurer, LGIT, will provide training on disability issues every other year for six years to staff of the 120 Maryland municipalities it insures.

After the settlement was announced, Pathways' attorney Beth Pepper, who specializes in disability rights cases, hailed it is "a major legal precedent for people with psychiatric disabilities."

In an interview with *Psychiatric News*, she explained that this is the first case in which the Americans With Disabilities Act, in conjunction with charges of violating the 14th Amendment's equal protection clause, has been used successfully in a lawsuit against a municipality.

She urged all governments to pay attention to the message the suit sends, namely that "communities should work closely with nonprofits serving disabled populations and put their energies into helping [these individuals] become integrated in community life rather than barring them from it."

As for Pathways, it is still in its rural location. Most of the downtown Leonardtown redevelopment has occurred as planned, so no other suitable sites have come on the market.

[*Pathways, et al. v. Town of Leonardtown*, U.S. District Court for the District of Maryland, No. DKC 99-1362.] ■

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Mentally Ill Inmates Win Right to Discharge Planning

To settle a class-action suit against it, New York City has agreed to implement a comprehensive discharge-planning program that will follow mentally ill inmates into the community.

BY KEN HAUSMAN

Mentally ill inmates in New York City jails will soon benefit from individualized discharge planning now that the city has decided to throw in the towel in its protracted legal battle to avoid establishing a discharge-planning program.

Before it decided to settle the case, the city lost two appeals of a July 2000 ruling by a state trial court that ordered the city to begin such a program. The court issued an injunction that barred New York City from continuing to violate the city's Mental Hygiene Law by failing to implement discharge planning that continues the mental health treatment inmates were receiving when incarcerated.

About 130,000 individuals are incarcerated in New York City jails each year, and 15,000 of them have a severe and persistent mental illness, according to the Bazelon Center for Mental Health Law, which submitted an amicus curiae brief supporting the position of the plaintiff in the case *Brad H., et al. v. City of New York, et al*. In all, about one-fourth of city jail inmates need mental health treatment.

The suit against the city argued that while city law mandates discharge planning that provides continuity of care for inmates receiving mental health care, the city routinely sends inmates back to the community with no postdischarge arrangements in place.

It is common for mentally ill inmates to be discharged without a supply of the psychotropic medication they were taking while incarcerated, follow-up therapy appointments, or help in obtaining housing or public assistance payments, according to the Bazelon center's amicus brief.

That brief was also submitted by 11 organizations including the National Alliance for the Mentally Ill, National Orthopsychiatric Association, Coalition of Voluntary Mental Health Agencies, and New York Association of Psychiatric Rehabilitation Services, among others.

Inmates in Revolving Door

Without follow-up care, many of these inmates would have a difficult time accessing treatment services after discharge, since a substantial portion were homeless and dependent on Medicaid at the time of their arrest. "As a result of the abrupt termination of their treatment, many inmates experience a relapse of symptoms [and] an increased risk of suicide, and frequently wind up in a 'revolving door' of successive periods of hospitalization and reincarceration, interrupted by periods of release in which their psychiatric treatment is suspended and their symptoms recur," the amicus brief points out.

The plaintiffs' arguments centered on several issues including that U.S. jails have become de facto mental health care facilities filled with people who would probably not be there if they had received care in the community or psychiatric hospitals. They also emphasized that mental illnesses can be successfully treated, that almost all major mental health organizations, including APA, insist that discharge planning is an essential part of care for incarcerated individuals, and because inmates lose Medicaid coverage and other public assistance, it is unlikely that they have the resources to restore all these benefits without help prior to discharge.

Among the arguments upon which the city relied in defending itself against the charges are that jails, by their nature, house a transient population, thus presenting an "insurmountable barrier" to comprehensive discharge services. The city also said that a mandated discharge-planning system could not work because many inmates leave jail before jail officials have the chance to arrange evaluations by mental health professionals. Addressing all inmates' crucial mental health care needs would require financial investment whose dimensions make it prohibitive, the defendants maintained to no avail.

Settlement Mandates

The terms of the settlement, in which the city did not admit liability, require that all inmates receive an assessment of their need for continuing mental health treatment, public benefits, housing, and transportation to that housing. Inmates have the right to decline the services mandated under the agreement.

City officials are also to "create a mechanism to allow significant others and other members of the community who have clinical information. . .relevant to the mental health treatment" of an inmate to relay that information to a jail's discharge-planning staff. In addition, every inmate is to receive a medical assessment within the first 24 hours of incarceration and, if a need is identified at that time, a mental health care assessment with three days.

A discharge plan for those who are found to need mental illness treatment while in prison is to be completed within seven days of the mental health assessment for those in segregated mental health units, and 15 days for those in the general population. Jail officials are to provide these inmates with a written discharge summary at the time of release from jail.

The settlement also mandates that the city release prisoners during daylight hours,

please see ***Inmates*** *on page 49*

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annual meeting

Wanted: Psychiatrists to Run For Better Mental Health

A psychiatrist hopes to persuade the Bay-to-Breakers Foundation to include organizations that provide treatment for mental illness among the charities it funds through San Francisco's annual Fun Run.

BY MARK MORAN

APA members and their families have an opportunity to "walk the talk" on behalf of treatment for mental illness and substance abuse at this year's annual meeting in San Francisco.

Psychiatrist Ron Sterling, M.D., of Seattle is seeking other APA members and their families to join the "Mental Health Matters!" team that will take part in San Francisco's famous Bay-to-Breakers Fun Run, on Sunday, May 18.

Sterling said he hopes to have the largest team in the "team challenge," creating publicity—"a buzz," as he put it—about the importance of treatment for mental illness and substance abuse.

For now, the team can raise money only for the charities supported by the Bay to Breakers Foundation, which sponsors the race. But Sterling hopes the publicity created by the team will persuade the foundation in the future to include among those charities organizations that provide treatment for mental illness and substance abuse.

Sterling is working with several groups to form a coalition to advocate for just that. "Accomplishing the coalition-building part of the mission has been the most daunting and difficult task so far," he said. "Rev. Chet Watson, president of the California chapter of the National Alliance for the Mentally Ill (NAMI), has been very supportive, and so have the California chapters of the National Association of Social Workers and Marriage and Family Therapists. However, as of March 4, several other organizations and university departments in central California have not responded to this effort."

Sterling said that a precedent was set in his home city of Seattle. "The Greater Seattle Chapter of NAMI is one of the forerunners of mental health fundraising fun runs," he said. "They started the annual Seattle Move for Mental Health Fun Run in September 2001, and we are in the midst of organizing the third annual run for this September.

"Last year, I volunteered to be a team captain," Sterling said. "The team was made up of Washington State Psychiatric Association members and their friends. It was our first team, and we made a good showing. We plan on being bigger and better this year. This year I am assisting the Seattle run's work group to raise the run's profile with larger Seattle-area corporations to sponsor corporate teams. When large corporations get on board and support their workers to form teams to represent the corporation, media and individual attitudes often start changing."

Sterling said it's as much about raising awareness as it is about raising money. "In my opinion, that is why fun runs and walks are so attractive," he said. "They don't put a lot of pressure on people's belief systems. Fun runs allow people to have fun while they help others and contribute to their community. In a sense, they provide a form of desensitization for traditionally stigmatized issues."

The team will have members who run to compete, run for fun as a group, walk for fun, and many who may not walk at all. Sterling urged APA members who can't participate directly in the run to join the team and support the effort by wearing the team logo name tag to APA sessions on Sunday, May 18.

Team members will receive their team pins and running bibs either by mail or at one of two meetings before the race. All team information and meeting changes will be posted on the Web site.

"As team captain, I will have a wireless phone with me so team members can contact me," Sterling said. "We are developing a team T-shirt, but have not yet found any funding to help pay for costs. Team T-shirts may become available depending upon how many sign up and whether members will be willing to pay a nominal fee for a shirt."

He added, "We need team members. This will be fun, collegial, and good for our relationship with Bay Area residents and organizations."

People who wish to join the team can find easy-to-follow instructions at the Web site <www.MentalHealthRun.org>, where they can register online. ■

How to Register

There are two easy ways to register for APA's 2003 annual meeting, which is being held May 17 to 22 in San Francisco:

- Go to APA's Web site at **www.psych.org,** click on the annual meeting logo, and select "Online Registration." Also, reserve your hotel room by clicking on "Reserve Your Hotel Online."
- Fill out the forms in the Advance Registration Information Booklet, which was mailed to all members in January. If you have not yet received your packet, call the APA Answer Center at (888) 35-PSYCH; from outside the U.S. and Canada, call (703) 907-3800.

The deadline for advance registration is **April 12** for U.S. and Canadian registrants and **April 5** for all others.

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Tired of Stigmatizing Media Reports? Learn to Use Radio to Your Advantage

Would you like to learn how to use the radio to decrease stigma in this country? Then be sure to attend this workshop at APA's annual meeting in May.

The media can be psychiatry's worst friend—but also one of its best. While the media all-too-often perpetuate stigma by giving one-dimensional reports on news involving people with mental illness, they also help decrease stigma when they present well-researched reports or programs that serve to educate the public about mental illness and effective treatments.

To help psychiatrists learn more about how to use at least one medium—radio—in this positive way, the APA Alliance is sponsoring a workshop at this year's annual meeting in San Francisco titled "On the Use of Radio to Combat Stigma and to Improve the Image of Psychiatry." It will be held on Monday, May 19, at 11 a.m. in Salons 14 and 15 on the lower B-2 level of the Marriott.

The chair of the workshop will be Harvey L. Ruben, M.D., M.P.H., a former talk-show host on the NBC Radio Network and current president of the National Association of Medical Communicators. He is also a clinical professor and director of continuing education in the department of psychiatry at Yale Medical School.

Also participating in the workshop are other seasoned psychiatric broadcasters who have a wealth of experience on radio and in the media in general: Fred Goodwin, M.D., Linda Austin, M.D., Michael Blumenfield, M.D., and Harry Croft, M.D.

These psychiatrists have extensive experience in the media and involvement in APA media activities. Ruben hosted a three-hour, call-in show every Saturday and Sunday night on the NBC Radio Network for 11 years and chaired APA's Joint Commission on Public Affairs (JCPA) for six years. Blumenfield is also a past chair of the JCPA and the host of "Talking About Mental Health" on WVOX in New Rochelle, N.Y. Both Goodwin and Austin are hosts of nationally syndicated radio programs; Goodwin's is titled "The Infinite Mind," and Austin's is "What's on Your Mind?" Croft, who has also been involved with APA's public affairs activities, served on the Board of the National Association of Medical Communicators and had a nationally syndicated "Medical Minute" series on television.

The presenters will outline specific techniques for dealing with local radio in small and large markets and national radio in both the commercial and public broadcasting formats. They will also teach participants how to present information in ways that are understandable and appealing to a general audience and give examples of using radio to combat stigma and improve the image of psychiatry. The presentations will be embellished by the use of examples and vignettes from actual radio experiences.

The purpose of this workshop is to sensitize members of APA and the APA Alliance to the valuable opportunities that radio offers in giving the public a greater understanding of psychiatry and those who suffer from a mental illness. ■

Get Your Free Insurance Consult

Bring your risk management and malpractice insurance questions to Booth #1106 at APA's 2003 annual meeting. Meet with the experienced psychiatric insurance counselors and risk managers from the Psychiatrists' Program, the APA-endorsed Psychiatrists' Professional Liability Insurance Program. Complimentary copies of the HIPAA resource manual will be available for current Program participants.

Tee Up at Presidio Course

A day in the California outdoors is just what APA golf lovers need during their stay at the annual meeting.

The Golfers of the APA (GAPA) invites APA members to participate in its 2003 golf tournament to benefit the American Psychiatric Foundation.

The tournament will be held Monday, May 19, at the Presidio Golf Course in San Francisco. This course is home to a distinguished golfing legacy forged by the giants of history and golf's greatest legends, including Theodore Roosevelt, Dwight Eisenhower, Joe DiMaggio, Byron Nelson, Ben Hogan, and Arnold Palmer. The cost per person is $200, which covers roundtrip transportation, greens fees, cart, lunch, gifts, and prizes.

Those interested in entering the tournament should contact Stan Jennings, M.D., by e-mail at MBears@attbi.com, by fax at (804) 320-2050, by phone at (804) 320-7881, or by mail at W. S. Jennings Jr., M.D., 7149 Jahnke Road, Richmond, Va. 23225. ■

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Psychiatry Residency Census Finds Encouraging News

A gradual decline in the number of psychiatry residents in training appears to have stopped, according to findings from the 2001-02 APA Census of Psychiatry Residents.

BY EVE BENDER

A nationwide census of psychiatry training programs shows that the number of residents training in psychiatry has stabilized over the past year, but that small changes in the demographics of psychiatry residents could herald important developments in the future.

APA conducts the Internet-based survey, known as the Graduate Medical Education (GME) Track, in collaboration with the Association of American Medical Colleges and the American Medical Association. The survey has a number of uses, including the assessment of the workforce in psychiatry.

This year's census is based on an 83 percent response rate from 493 residency training programs in psychiatry accredited by the Accreditation Council for Graduate Medical Education for general, child and adolescent, geriatric, addictions, and combined specialty psychiatric training.

The survey showed that there were 52 more psychiatry residents in 2001-02 than in the previous academic year, for a total of 5,766 psychiatry residents in training last year (see chart).

However, between the 1996-97 and the 2000-01 surveys, the field saw a net loss of 362 psychiatry residents, mostly due to the downsizing and merging of psychiatry residency programs.

Sidney Weissman, M.D., a professor and director of psychiatric training at Northwestern University and an expert on workforce issues in psychiatry, did not attach much significance to the one-year gain and said it remains to be seen whether the one-year increase develops into a positive trend.

Weissman pointed to the fact, however, that the characteristics of psychiatry residents shifted slightly. APA's report contained several charts that included data on international medical graduates (IMGs), and one showed a 2 percent decrease in the proportion of PGY-1 residents who are IMGs over the past year—from 42.8 percent in 2000-01 to 40.8 percent in 2001-02.

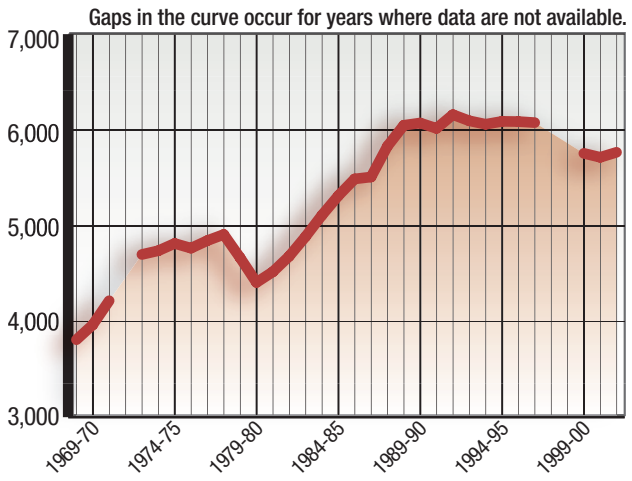
Of all of psychiatry's subspecialty training programs, geriatric psychiatry was the most popular with IMGs in the 2001-02 survey: about 67 percent of geriatric psychiatry fellowships were filled by IMGs. In addition, more than half of those training in consultation/liaison psychiatry (56 percent) were IMGs.

"American psychiatry could not be practiced as it is today without IMGs," Weissman said.

The 2001-02 survey also showed that women and men continue to be evenly distributed in psychiatry residency training programs. Weissman noted that the proportion of women in psychiatry residency training has been on the upswing for years and said he expects the trend to continue to the point where women will outnumber men in the field.

The results from the 2001-02 Census of Psychiatry Residents is posted on the Web at <www.psych.org/med_ed/census_main.cfm>. ■

Choosing Psychiatry Over the Years



Source: APA Office of Graduate and Undergraduate Education Report, "Census of Psychiatry Residents 2001-2002"

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Many Anorexia Deaths Linked To Alcoholism, Suicide

Anorexia nervosa continues to be a serious illness with a high death rate, a new longitudinal, prospective study reveals. Also, starvation may not be the cause of death.

BY JOAN AREHART-TREICHEL

Anorexia nervosa should be on all psychiatrists' radar screens, suggests a new study reported in the February *Archives of General Psychiatry*.

The study has produced several important findings, one of the investigators, David Herzog, M.D., told *Psychiatric News*. Herzog is a professor of psychiatry at Harvard Medical School and head of the Harvard Eating Disorders Center at Massachusetts General Hospital.

"The mortality rate from anorexia nervosa is extraordinarily high," Herzog said, and the cause of death in anorexia nervosa is not always starvation.

Certainly, this is not the first study to document high death rates in subjects with anorexia. Some studies reported during the 1990s did so, but what makes the study by Herzog and his colleagues especially compelling is that it is based on more recent cases than those reported in earlier studies and on cases taken from the community, not just from inpatient populations.

Between 1987 and 1991, Herzog and his coworkers recruited 136 patients with anorexia nervosa and 110 patients with bulimia nervosa to participate in their investigation. Most of these patients were seeking outpatient treatment for their eating disorder at the Massachusetts General Hospital Eating Disorders Unit or at other Boston eating-disorder programs. Most of the patients received some form of treatment for their disorder.

Herzog and his colleagues then followed the fates of these 246 subjects through 1998 via follow-up interviews, phone calls, medical records, death certificates, and autopsy reports. "This was a carefully done study without subjects being lost to follow-up," Herzog explained to *Psychiatric News*. "So we can trust our data set pretty well."

By the end of 1998, 11 subjects had died—10 who had been diagnosed with anorexia and one with bulimia. Of the 10 anorexia subjects who died, the direct cause of death in four instances was suicide.

Also, the researchers scrutinized the data that they had collected about the 10 anorexia subjects at the time they were enrolled in the study and during the nine years or so that they were followed up to see whether any of the subjects' characteristics at the start of or during the study might have predicted their deaths. They identified two characteristics: duration of illness and alcohol abuse. Indeed, of the 10 anorexia subjects who died, four had had a history of alcoholism at the start of the study, two more acquired alcohol problems during the study, and alcohol appeared to play a direct role in the deaths of two subjects.

These results have a number of crucial implications for clinical psychiatrists, Herzog and his team believe. First, anorexia nervosa (but not bulimia nervosa) appears to have a high risk of death associated with it—even when patients get treatment for it.

"The mortality rate in the anorexia subjects was close to 12 times that which you would see in a similar age and gender population," Herzog told *Psychiatric News*. "So individuals continue to die from anorexia nervosa despite more information about it being available than in previous years. In other words, it continues to be a very serious illness."

Second, suicide appears to be a frequent cause of death in anorexia patients. "The suicide rate in our subjects was some 60 times higher than you would see in a similar age and gender population," Herzog observed.

Third, "the longer a patient has been ill when a clinician encounters him or her, the more concerned the clinician should be about the risk of death," Pamela Keel, Ph.D., an associate professor of psychology at Harvard University and the lead investigator in the study, told *Psychiatric News*.

The anorexia subjects in the study had the disorder anywhere from three months to more than 25 years. While "it would be possible to calculate the mean duration of illness among subjects who died, this number would be specific to these women and would not necessarily reflect a number that clinicians should refer to," said Keel.

Fourth, the combination of alcohol and anorexia is "a particularly lethal combination," said Herzog. And as he and his team advised in their study, "Physicians treating patients with anorexia nervosa should carefully assess patterns of alcohol use during the course of care because one-third of [subjects] who had alcoholism and died had no history of alcohol use disorder at intake."

Finally, "not all the anorexia subjects who died were severely underweight," Herzog stressed. "In fact, a number were at about normal weight or even above normal weight. So just because one achieves normal weight in these subjects is not a reason to discontinue monitoring them."

The study was funded by grants from the National Institute of Mental Health, the Harvard Eating Disorders Center, Eli Lilly and Company, and the Rubenstein Foundation.

An abstract of the study, "Predictors of Mortality in Eating Disorders," is posted on the Web at <http://archpsyc.ama-assn.org/issues/v60n2/abs/yoa10275.html>. ■

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Psychiatric Care Lowers IBS Treatment Costs

A new study showing the cost-effectiveness of psychotherapy and antidepressants in treating irritable bowel syndrome highlights the value of psychiatric treatment in many medical illnesses.

BY MARK MORAN

Both psychotherapy and paroxetine appear to improve health-related quality of life for patients with irritable bowel syndrome (IBS), and at no additional cost.

"Improvement in overall health-related quality of life is possible even if the pain does not greatly improve," said Francis Creed, M.D., a professor of psychological medicine at the university department of psychiatry at Manchester Royal Infirmary in Manchester, England.

"If patients with severe IBS do not respond to usual treatment, an SSRI antidepressant or referral to psychotherapy is worth trying," Creed told *Psychiatric News*. "Exploration of psychological problems, even if they are not very severe, may well lead to improvement in health-related quality of life."

Creed and colleagues published results comparing psychotherapy and paroxetine for IBS in the February issue of *Gastroenterology*.

In the study, 257 subjects treated at seven British hospitals for IBS were randomized to receive either psychotherapy, 20 mg of paroxetine for a period of three months, or treatment as usual—defined as whatever treatment was deemed appropriate by the patient's treating physician.

Psychotherapy consisted of one two-hour and seven 45-minute sessions of "psychodynamic interpersonal therapy" delivered over three months.

Creed and colleagues found at one-year follow-up that abdominal pain was similar in all three groups. But both psychotherapy and paroxetine were superior to treatment as usual in improving the physical aspects of health-related quality of life, as measured by the SF36 Health Survey.

Importantly, psychotherapy—but not paroxetine—was associated with a significant reduction of health care costs compared with treatment as usual. Psychotherapy was associated with a total cost of $976 (U.S. dollars) compared with paroxetine at a cost of $1,252.

Treatment as usual was associated with a cost of $1,663, according to the study.

Creed says that many patients with irritable bowel syndrome typically don't seek treatment at all or use over-the-counter products that may not be helpful. Most patients who do seek help from a gastroenterologist achieve some success with dietary modifications and antispasmodic or other medical therapies.

Yet a sizable cohort remains that is not helped, Creed says. And it is among this treatment-refractory group that the highest prevalence of psychiatric illness is found.

Mind-Body Interaction

Creed and others say IBS is a condition that highlights the mental and emotional component of much medical illness, refuting the traditional dichotomy of mind and body. Among clinic patients with IBS, approximately 50 percent have significant anxiety and depression, Creed said.

"For some patients there is primarily an infective, dietary, or other cause," she told *Psychiatric News*. "For a small number of people it is primarily anxiety and depression. For the majority, however, there is a physical component together with a psychological component."

Constantine Lyketsos, M.D., a professor of psychiatry and behavioral sciences at Johns Hopkins University School of Medicine, called the study "extremely important," noting that there have been few controlled cost-effectiveness studies of the best way to treat IBS.

Study Proves Treatment Value

"This study is showing not only that treatment works and which treatments work, but also the effect on cost," Lyketsos told *Psychiatric News*. "In this particular case, it appears that it actually reduces health care costs to treat IBS in a particular way."

Lyketsos, who is chair of APA's Committee on Consultation-Liaison Psychiatry and Primary Care Education, emphasized that the study demonstrates the value of psychiatric treatment of a condition typically thought of as medical illness. "Those of us in psychosomatic medicine have known this, and this study provides controlled-trial evidence to drive it home," he said.

Lyketsos said that while in most cases there is no known organic cause for the condition, the suffering and distress experienced by patients are real. "The issue is the functioning of the gut, which is affected by the patient's perceptions," he said. "The problem isn't in the gut necessarily, but how the brain interacts with the gut."

At press time, Lyketsos said that the American Board of Medical Specialties is expected to endorse psychosomatic medicine as a new psychiatric subspecialty (*Psychiatric News*, September 6, 2002).

"This study is an example of what this new field is going to do for psychiatry," he said. "There is going to be more of this kind of work at the research and clinical levels to show how psychiatric care of medically ill patients makes a difference."

An abstract of the study, "The Cost-Effectiveness of Psychotherapy and Paroxetine for Severe Irritable Bowel Syndrome," is posted on the Web at <www2.gastrojournal.org> under the February issue. ■

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Cholesterol Metabolism May Provide Alzheimer's Clue

With the discovery of a new genetic risk factor for late-onset Alzheimer's disease, scientists are zeroing in on an overall theory of the pathology underlying the characteristic loss of cognitive function and ensuing dementia.

BY JIM ROSACK

A new research report links an alteration in the gene that codes for an important brain enzyme—the enzyme controlling the rate-limiting step in the elimination of cholesterol from the brain—to a significantly increased risk for late-onset Alzheimer's disease.

The report, along with recently published reports involving earlier-onset forms of Alzheimer's disease, gives added support to the growing belief among researchers that the cellular mechanisms underlying the illness are centered around the brain's metabolism of not only amyloid but also cholesterol.

If the new report can be substantiated, the specific change in the coding of the gene studied—known as a polymorphism—would be the second involved in cholesterol metabolism implicated as a major risk factor for late-onset Alzheimer's disease (LOAD).

Alzheimer's disease is now generally divided into three categories, defined by age of onset: "familial," or early-onset Alzheimer's (EOAD), with onset occurring before age 65; LOAD, onset after age 65; and very late onset (VLOAD), after age 85.

While the resulting pathology—neuritic plaques and neurofibrillary tangles—are common to all forms of Alzheimer's, researchers are learning that the mechanisms underlying the development of the disease at different ages are indeed unique.

Amyloid Cascade

A large amount of research in molecular genetics, neuropathology, and cell biology has led to the amyloid cascade hypothesis, which remains the basis of researchers' current view of the pathology underlying all forms of Alzheimer's disease.

Three genetic polymorphisms have been linked to an increased risk of the least-prevalent of the three forms of Alzheimer's, EOAD: one involving the amyloid precursor protein (APP) and two recently discovered polymorphisms in genes coding for presenilin, which is one of several enzymes involved in the processing of APP.

Normally, most APP is broken down into two fragments, one that remains in the neuron and may play a part in gene transcription (although its function is not yet well understood) and a second, soluble form of amyloid that is secreted.

Each of the three polymorphisms linked to EAOD is thought to result in altered processing of APP, causing an increase in production of a much less soluble form of amyloid protein, known as beta amyloid, or Aß. Aß quickly accumulates and forms

Counseling should be "confined to those with a clearly positive family history. . .and an early [age at onset] in all family members."

the plaques seen universally in people with Alzheimer's, regardless of age at onset.

Amyloid plaques are directly toxic to nerve cells, causing cellular damage and eventually cell death. As part of that process, researchers believe, dying nerve cells release free radicals that activate enzymes in surrounding tissues. These enzymes lead to a chemical change in the tau protein, a critical intracellular protein that supports microtubules within the neurons. The altered tau dissociates from the microtubules—leading to neuronal collapse—and aggregates into the neurofibrillary tangles characteristic of Alzheimer's. It is these pathologic cellular changes that are thought to be directly responsible for the cognitive decline and dementia that are clinically termed Alzheimer's disease.

A new report from British researchers in the February issue of *Neurology* confirmed earlier reports of the link between EOAD and polymorphisms in the APP and presenilin genes. The team, led by J.C. Janssen, M.R.C.P., director of the Dementia Research Group at St. Mary's Hospital in London, completed genetic analyses of 31 individuals with probable or definite Alzheimer's whose age of onset was prior to 61. Of those patients with confirmed Alzheimer's, 82 percent carried a suspect polymorphism in either the APP or presenilin gene. For those with probable Alzheimer's, 77 percent had the polymorphism.

Jansen and his colleagues concluded that "because a molecular genetic diagnosis of an inherited disorder affects not only the patient, but also the entire family, genetic counseling must be an essential component of the diagnosis."

They wrote that counseling should be "confined to those with a clearly positive family history. . .and an early [age at onset] in all family members."

Cholesterol Link

While early-onset Alzheimer's disease is thought to be primarily an autosomal dominant disease directly involving amyloid processing—a patient needs only one copy of the polymorphism from either parent to

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potentially develop the disease—only recently have researchers been able to shed light on the genetic mechanisms potentially underlying LOAD.

Until now, the only gene clearly linked to LOAD was the gene coding for apolipoprotein E (APOE), which is the main cholesterol transport protein responsible for shuttling cholesterol back and forth as needed across the neuronal membrane. One particular APOE polymorphism (APOE-E4) has been shown to increase serum cholesterol levels and is a major risk factor for LOAD, including a reduction in the average age of onset by about 10 years.

Now, according to a new report in the January issue of *Archives of Neurology*, a common, single base substitution within the gene coding for CYP46 significantly increases the risk of developing late-onset Alzheimer's. CYP46, found only in the brain, is a member of the cytochrome P450 family of proteins. It is responsible for the addition of a hydroxyl group to cholesterol, which results in cholesterol becoming much more soluble and allowing it to cross the blood-brain barrier to exit the brain.

The CYP46 enzyme regulates levels of brain cholesterol, researchers believe, through a feedback mechanism that allows the amount of soluble cholesterol leaving the brain to match closely the amount of cholesterol that is normally synthesized or routinely recycled (through APOE) within the brain. The end result, under normal conditions, is a fairly constant level of cholesterol in brain tissues.

A team led by Andreas Papassotiropoulos, M.D., director of the division of psychiatry research at the University of Zurich, believes the polymorphism he and his team studied—a change of just one base in the CYP46 gene from cytosine (C) to thymine (T)—leads to a decrease in functioning of CYP46, causing cholesterol levels in the brain and cerebrospinal fluid to reach higher-than-normal levels.

Because other research has shown that depletion of brain cholesterol leads to a reduction in Aß, and some cholesterol-lowering medications have been linked to lower prevalence of LOAD (see box below), the team hypothesized that the increase in cholesterol levels due to the single base polymorphism would translate into an increase in risk for LOAD.

Papassotiropoulos and colleagues report that the CYP-TT polymorphism (substitution of T for C in both copies of the subject's CYP46 gene) is fairly common, occurring in 44 percent of the overall population they studied. They first studied postmortem brain tissue samples from 55 nondemented elderly patients, measuring the amount of Aß deposition (termed Aß load.)

Aß load in the brain tissue samples was significantly linked to the CYP46-TT polymorphism. Interestingly, the load was highest in tissue samples that were positive for both CYP46-TT and APOE-E4. Aß load was lowest in subject tissues without either the CYP46-TT or APOE-E4 polymorphisms while it was intermediate—and roughly equal—in those which had one or the other, but not both.

The researchers next looked at levels of Aß and tau in the cerebrospinal fluid (CSF) of 38 living patients with known Alzheimer's and 25 control subjects. CSF levels of Aß were highest in Alzheimer's patients who were positive for the CYP46-TT polymorphism, even significantly elevated from levels of Aß in patients known to have Alzheimer's, but were negative for CYP46-TT.

CSF levels of tau were markedly higher in patients with Alzheimer's than in the control group. Those subjects with CYP46-TT and APOE-E4 with clinically diagnosed Alzheimer's had the highest levels of CSF tau, followed by those that had both polymorphisms but no diagnosis. Again, roughly equal and intermediate levels were found in patients who had one or the other polymorphism, but not both, suggesting a relatively equal effect from each polymorphism to elevate both Aß and tau. The lowest levels were seen in patients that were negative for both polymorphisms.

Finally, Papassotiropoulos performed genetic-association studies on two separate

please see ***Cholesterol*** *on page 52*

Statin Studies Show Mixed Results

A number of animal studies have indicated that the amount of Aß produced in the brain is affected by the amount of cholesterol absorbed from the animals' diet. Yet studies of cholesterol-lowering medications in human clinical trials have been conflicting as well as disappointing.

Reducing cholesterol intake has been shown in rabbits, mice, and guinea pigs to reduce total brain levels of Aß (see story above). At least one study in animals has shown that atorvastatin (Lipitor) reduces actual plaque formation as well.

On the human side, at least two retrospective studies, both published in 2000, have indicated that patients who had taken coenzyme-A reductase inhibitors, more commonly known as "statins," experienced as much as a 70 percent decrease in the prevalence of Alzheimer's. However, a recent report by James Shepherd, M.D., professor and chair of the department of pathologic biochemistry at the University of Glasgow, indicates the question of benefit is still not well answered.

Shepherd, the principle investigator of the Prospective Study of Pravastatin in the Elderly at Risk (PROSPER), reported at last November's meeting of the American Heart Association that pravastatin (Pravachol) did not appear to help cognition. The drug did result in a 19 percent reduction in death due to coronary artery disease.

Shepherd had hypothesized that of the 5,800 patients in the study, those taking pravastatin would see a slowing of age-related cognitive decline, relative to those receiving placebo, over a three-year period. At the end of the study, however, scores on the Mini-Mental Status Exam (MMSE) were not significantly different between the two groups. (All subjects scored above 24 at baseline, with the average MMSE score equal to 28 in both the prevastatin group and the placebo group.)

Similarly, the Heart Protection Study, with more than 20,000 subjects, also failed to show any effect of simvastatin (Zocor) on cognitive function.

Shepherd noted that while observational studies have suggested that statins can reduce the risk of dementia, neither small, randomized, placebo-controlled studies nor large-scale clinical trials have confirmed any benefit.

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Stem Cells May Hold Key To Treating Brain Disorders

New research shows that transplanted stem cells migrate to the brain and assume the function of neurons, holding out the promise of therapies for Alzheimer's disease, Parkinson's, and other neurodegenerative diseases.

BY MARK MORAN

The therapeutic use of stem cells, already promising radical new treatments for cancer, immune-related diseases, and other medical conditions, may someday be extended to repairing and replenishing the brain.

Stunning new research, still in its early stages, suggests that stem cells—the primitive "starter" cells found in bone marrow that have attracted the attention of researchers worldwide for their regenerative capacities—could offer breakthrough therapies for stroke, brain injury, Parkinson's disease, Alzheimer's disease, and other neurodegenerative conditions.

Much of the research on how stem cells might work to repair or replenish the brain has been in animals. But now, scientists at the National Institutes of Health (NIH) have shown that adult human bone-marrow cells can enter the brains of human transplant recipients—and that those cells will generate new neurons in the brain.

"This is an example of how the whole field of stem-cell plasticity is really exploding," said Eva Mezey, M.D., Ph.D., lead researcher on the study. She is head of the in-situ hybridization facility at the National Institute of Neurological Diseases and Stroke at the NIH. "I think it can give a completely new direction to medicine, adding to presently available treatments all kinds of new cell therapies, not only for the brain but all over the body."

Cross-Gender Strategy

Mezey and her colleagues examined postmortem brain samples from four female patients with leukemia or immune-related diseases who had received bone-marrow transplants from male relatives. The strategy of looking at cross-gender transplant recipients provided the researchers a ready-made way to determine whether transplanted stem cells had migrated to the brain: any such cells would invariably carry a Y chromosome.

True to their hypothesis, sophisticated cell-staining technology showed that all four patients had Y-positive cells in their brain samples.

Most of these cells were not neurons, Mezey noted. But some of them were, indicating that the stem cells had not only migrated to the brain, but had "differentiated"—assuming the function of their surroundings, precisely as they have been found to do in other parts of the body.

Interestingly, most of the migrated stem cells were in the hippocampus. "The hippocampus is involved in memory management," she said. "One can imagine that in an area of the brain where new connections are being made all the time, new cells will be needed all the time."

Brain 'Recruits' Cells

So, she said, something in the function of the brain is "recruiting" transplanted stem cells from the bloodstream to an area in the brain where they are needed most. That finding complements animal studies showing that transplanted stem cells migrate to—and differentiate into the form and function of—surrounding cells in brain areas that are damaged.

Uncovering that function is a challenge for the future.

"If we know the factors that recruit stem cells from the circulation, one can imagine injecting those factors into the site of a lesion—say, from a stroke—and increasing the number of circulating stem cells," Mezey said. Mezey's findings appear to be the first human evidence of the migration and differentiation of transplanted stem cells in the brain, adding to a large and growing body of animal and laboratory research.

But she and other scientists in the field note that one of the most important revelations to emerge from a decade of research in this area is that the brain itself—in addition to recruiting transplanted stem cells from the bloodstream—appears to be continually producing its own stem cells, and repairing and replenishing itself.

Darwin J. Prockop, M.D., director of the center for gene therapy at Tulane University School of Medicine in New Orleans, noted that the finding overturns a long-held belief that the brain houses a finite number of cells that are lost irrevocably when they die.

Yet it appears that the brain's natural production of stem cells occurs far too slowly, generating too few cells to repair the damage that typically occurs in the case of a stroke, spinal-cord injury, or neurodegenerative disease.

A key, then, to realizing the therapeutic potential of stem cells in the brain is increasing the volume of their production, Prockop explained. In contrast to Mezey, who looked at whole stem cells (which were typically used at the time when the patients in her study had been transplanted), Prockop and colleagues have studied specialized cells within bone marrow known as marrow stromal cells (MSCs). MSCs appear to have remarkable regenerative capacities, stimulating the growth of new cells

please see ***Stem Cells*** *on page 50*

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Twin Study Adds Fuel To Marijuana Debate

Findings from a new study of more than 300 sets of twins show that early use of marijuana, independent of genetic background and environment, is associated with later drug use and abuse.

BY EVE BENDER

The results of a new study have bolstered the theory that marijuana is a "gateway" drug with evidence showing that those who use marijuana before age 17 are two to five times more likely to use, abuse, or become dependent on other drugs.

A research team from the United States and Australia reported these findings in the January 22 *Journal of the American Medical Association*.

Recognizing that genetic and environmental factors can influence a person's decision to use marijuana or other drugs, the researchers studied a sample in which they could control for these factors while studying the effect of early marijuana use.

They studied 311 pairs of same-sex twins in which one twin in each pair began using marijuana before age 17 and the other did not. The twins came from the Australian Twin Register, a volunteer listing of twins born from 1964 to 1971.

The data are based on a single phone interview conducted between 1996 and 2000, when the mean age of the sample was 30.

"By studying twins who are discordant for cannabis use, we had the ideal way of controlling for genetic and family backgrounds," said lead author Michael Lynskey, Ph.D., a visiting professor of psychiatry at the Washington University School of Medicine in St. Louis and a senior research fellow at the Queensland Institute of Medical Research in Brisbane, Australia.

"The twins had the same parents, came from the same socioeconomic background, and, in the case of identical twins, shared the same genetic material," he told *Psychiatric News*.

The researchers found that among those who used marijuana before age 17, the odds of using other drugs increased. For instance, the odds of sedative use tripled, opioid use more than doubled, and hallucinogen use increased fivefold compared with twins who either never used marijuana or used the drug only after age 17.

In addition, early marijuana users had higher rates of abuse of and dependence on alcohol and other drugs than their twins.

Of the 311 twins who used marijuana before age 17, 148 (47.6 percent) abused or became dependent on any illicit drug compared with 102 (32.8 percent) of the 311 twins who did not use marijuana before age 17.

About 46 percent of early marijuana users later abused or became dependent on marijuana, compared with 32 percent of those who did not use marijuana before 17.

Early users also had higher rates of alcohol dependence (42.8 percent versus 29.6 percent) and abuse or dependence on cocaine and stimulants (12.5 percent vs. 4.5 percent).

Lynskey said that after controlling for genetic and environmental factors, he did not expect to find a link between early marijuana use and later drug use problems. "We were quite surprised," he said.

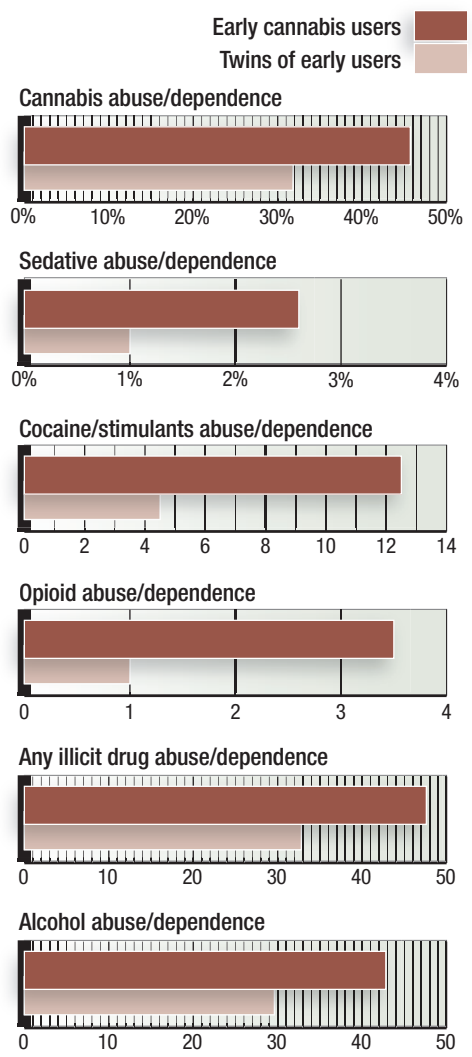
In addition, he acknowledged that although the researchers controlled for genetic and environmental factors to the best of their abilities to test the effects of early marijuana use, "nonshared environments" could not be accounted for and may have played a role in why the twins used marijuana at an early age or other drugs later in life.

For example, the parents may have treated one twin differently from the other, or each twin may have had his or her own group of friends outside school—factors

please see ***Twin Study*** *on page 52*

A Harbinger of More Drug Abuse?

The study tracked twin pairs discordant for cannabis use before age 17. The data below are for lifetime prevalence.



Source: *Journal of the American Medical Association*, January 2003

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Combined Therapies Produce Better Bipolar Outcomes

Researchers looking for ways to prevent relapse in bipolar disorder patients find that patients benefited most from a combination of cognitive therapy and medication.

BY CHRISTINE LEHMANN

Cognitive therapy and medication is superior to medication alone in bipolar patients, according to a study published in the February *Archives of General Psychiatry*. The combined treatment prevented relapses, alleviated symptoms, and promoted social functioning.

Researchers in the department of psychology and psychological medicine at the Institute of Psychiatry in London studied 103 patients on an outpatient basis who met *DSM-IV* criteria for bipolar 1 disorder. The patients were similar in age, age of onset of bipolar disorder, depression and mania rating scores, number of previous episodes of depression, mania, and hypomania, and number of hospitalizations.

However, the cognitive therapy group was slightly older and had a slightly higher number of previous episodes and hospitalizations than the control group, according to researchers. In contrast, the control group had slightly higher depression rating scores.

The majority of patients in both groups were taking mood stabilizers, about half were taking major tranquilizers, and about one-quarter were taking antidepressants.

"The purpose of this study was to recruit a large sample of patients with bipolar affective disorder who were experiencing frequent relapses despite the use of mood stabilizers. We wanted to investigate the efficacy of cognitive therapy in conjunction with common mood stabilizers such as lithium carbonate, carbamazepine, and valproate sodium in the prevention of relapses," the authors wrote.

About half the patients received cognitive therapy and mood stabilizers, and the control group received mood stabilizers. Both groups had follow-up visits from community psychiatric nurses. During the first six months, the cognitive therapy group had a mean of three visits while the control group had a mean of eight visits. During the second six months, the cognitive therapy group had a mean of four visits and the control group had a mean of six visits, Lam told *Psychiatric News*.

The treatment group received 12 to 18 individual sessions of cognitive therapy during the first six months of the 12-month study and two booster sessions in the second six months.

The cognitive therapy used was designed by the researchers specifically for bipolar patients and had shown encouraging results in a previous small pilot study, they noted. The treatment consisted of the following elements in addition to traditional cognitive therapy treatment for depression:

- An emphasis on the need for combined medication and psychological therapies to help patients cope with stress.
- Cognitive-behavioral skills to monitor mood and initial signs of an episode of depression or mania and to modify behavior to prevent those initial stages from becoming full-blown episodes.
- An emphasis on sleep and daily routine to avoid sleeplessness triggering an episode.
- Identification and discussion of extreme goal-attainment attitudes driven by the patient's perception of "lost time" due to previous illness. The resulting behaviors could disrupt patients' sleep and daily routines, leading to more episodes.

"Cognitive therapy is well suited to teaching patients with bipolar affective disorder the relevant skills to better cope with their illness," the authors stated.

The group receiving cognitive therapy showed a significant reduction in extreme goal-oriented attitudes at six months compared with the control group, but the improvement was not maintained at 12 months.

"Our experience in working with highly driven patients was that these attitudes were difficult to change because they were highly valued by patients," the authors stated.

During the large one-year study, the cognitive therapy group experienced an average of nine episodes of bipolar disorder, major depression, mania, hypomania, and mixed mania and major depression compared with an average of 17 episodes for the control group.

The cognitive therapy group had an average of four hospital admissions during the 12-month study compared with an average of nine admissions for the control group for the same disorders, except for mixed episode.

Seventy-five percent of the control group patients relapsed during the first year compared with 44 percent of the cognitive therapy group.

The average number of days per episode for the group receiving cognitive therapy was significantly fewer than for the control group. In addition, the group receiving cognitive therapy showed fewer mood symptoms and less fluctuation in manic symptoms than the control group.

The limitations of the study included no measures of patients' sleep hygiene or routine and no control for the effect of attention or medication prescribed, according to the researchers.

An abstract of the study, "A Randomized Controlled Study of Cognitive Therapy for Relapse Prevention for Bipolar Affective Disorder," is posted on the Web at <http://archpsyc.ama-assn.org/issues/v60n2/abs/yoa20510.html>. ■

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Sen. Edward Kennedy tells those at a press conference last month in Washington, D.C., announcing the latest parity bills that Congress has "an opportunity with this legislation to shine a light on a dark corner of our society by making sure that we give people challenged by mental conditions the opportunity for progress and treatment." Looking on are (from left) Rep. James Ramstad (R-Minn.), Rep. Patrick Kennedy (D-R.I.), and Sen. Pete Domenici (R-N.M.).

Parity

continued from page 1

care costs to employers above the Congressional Budget office estimate of less than 1 percent.

A majority of members in both chambers and more than 250 national organizations support the legislation, according to Rep. Kennedy. President George W. Bush announced his support for parity last spring (*Psychiatric News*, May 17, 2002). A survey by the National Mental Health Association (NMHA) last September showed that 79 percent of Americans favored parity legislation regardless of whether it increases their insurance premiums slightly, according to an NMHA press release.

"It is time for Congress to stop talking and start acting to end insurance discrimination against our patients," said APA President Paul Appelbaum, M.D., in a press statement released on behalf of the APA-led Coalition for Fairness in Mental Illness Coverage. "This legislation makes the promise of full parity for persons with mental illness a reality. Study after study has shown that prompt, effective, medically necessary interventions to treat our patients save lives and money. . . . Insurance discrimination against persons with mental illness should be barred."

The coalition members are the National Alliance for the Mentally Ill, National Mental Health Association, American Hospital Association, American Managed Behavioral Healthcare Association, American Medical Association, American Psychological Association, Federation of American Hospitals, and National Association of Psychiatric Health Systems.

Rep. Kennedy said at the press conference, "I could throw out a slew of statistics about the cost of mental illness to society, to businesses, but this isn't about statistics—it's about American families; it's about lives wasted because the health care that can effectively treat people is put out of reach."

Kitty Westin of Minnesota described at the press conference her daughter's battle with anorexia nervosa, which lasted several months until her suicide in 2000 at age 21. Westin and her husband formed the Anna Westin Foundation to advocate for health insurance parity and better treatment on behalf of the approximately 8 million Americans with eating disorders. The Westins became friends with Wellstone after their daughter's death.

"We believed that we had purchased the Cadillac of health insurance plans and that, in the event of illness, our family would have access to the best care available and as long as we needed it," said Westin.

"Imagine our shock and anger when we discovered that our insurance company discriminated against people with mental ill-

please see ***Parity*** *on facing page*

What Do Parity Bills Provide?

The Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003 was introduced in the Senate and House last month. The bills, which apply only to group health plans offering mental health benefits, have the following provisions:

- Prohibit more burdensome financial requirements, including higher co-payments and deductibles, than those for nonpsychiatric medical benefits.
- Prohibit more stringent treatment limitations, including fewer hospital days and outpatient visits, than those for other medical benefits.
- Provide full parity for mental health conditions listed in the latest version of APA's *Diagnostic and Statistical Manual of Mental Disorders,* the industry standard manual used by Medicare, Medicaid, the Food and Drug Administration, the legal system, the Federal Employees Health Benefits Program (after which the legislation is modeled), and parity laws in 13 states.
- Provide coverage contingent on the mental health condition being included in an authorized treatment plan that follows standard protocols and meets medically necessary criteria.
- Exempt from compliance companies with 50 or fewer employees.
- No requirements for benefits related to alcohol or drug abuse.

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DSM Proposal

DSM-IV's segregation of personality disorders and mental retardation on Axis II misleads patients, family members, employers, insurance companies, and even some clinicians to think of these patients as having very pervasive and permanent psychiatric conditions that are beyond the reach of psychiatric treatment.

APA should take steps to place these patients on Axis I with other psychiatric disorders, leaving Axis II for nondisorder aspects of the patient that are important to the treatment, such as character traits, defense mechanisms, cognitive styles, V codes, and other important mental findings that are not disorders in themselves.

ROGER PEELE, M.D.
Rockville, Md.

Tread Lightly

I think Dr. Carl Cohen and the 50-some "concerned psychiatrists and mental health professionals" who signed on to the letter titled "Public Education Justified" in the February 7 issue may be a little presumptuous when advocating psychiatric analysis of U.S. policy and decision making with regard to the potential conflict in Iraq. The decision to go to war has been discussed by many thoughtful politicians on both sides of the argument for quite some time. The discussion has been hot and polemical at times, as well it should be, for many lives are at stake.

I do not believe for a second that psychiatrists and mental health professionals can be neutral and provide an objective analysis of the decision to go to war. Every professional carries with them his or her own biases and political viewpoints, which will undoubtedly determine the outcome of any analysis. What will we do with our findings? Accuse Mr. Bush, Mr. Cheney, and Mr. Powell of "irrational" decision making?

We need to be careful where we tread. Remember the stain on our profession after a number of psychiatrists publicly questioned the mental health of Barry Goldwater prior to the 1964 presidential election.

Of course we are experts in identifying and treating the psychological consequences of war in soldiers and civilians. It is hoped that our services will not be needed, but we must stand ready and mobilize quickly if the unfortunate happens. The respect that we will get from helping people at a critical moment will win more political allies, public

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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.

Parity

continued from facing page

ness. I will never forget the day we brought Anna to the emergency room. We were told by her treating physician that she was in critical condition—that her heartbeat was irregular, her liver was malfunctioning, her blood pressure was dangerously low, and her pulse was in the 30s."

Yet, she was repeatedly denied the care her doctors recommended, said Westin. "We were outraged. We knew that if we had brought Anna to the emergency room with almost any other illness besides an eating disorder, she would have been admitted immediately and stayed there until she was ready to be released. Instead, Anna struggled and suffered. When the insurance company denied her treatment, Anna used that to further deny her condition and resisted life-saving treatment."

She continued, "We were forced to guarantee payment for her treatment, which cost more than $1,600 per day. When Anna died, her sister told us that Anna had confided in her that she felt she was a financial burden on the family and that we would be better off if she died."

Peg Nichols of Washington, D.C., described her family's financial ordeal in caring for two sons diagnosed with bipolar disorder. "The combined cost of their medical treatment in the past six years has been more than $700,000, much of which my husband and I have paid for due to treatment limits, financial requirements, and downright payment denials by our health insurance providers.

"Our son's serious mental illnesses have put us on the brink of financial disaster twice, forcing us to shift funds and work overtime while simultaneously caring for our sons. Unlike many other medical illnesses, many managed care plans reimburse mental illnesses only at 50 percent or 60 percent, leaving families to pay for the remaining costs. Our sons—who face a lifetime of potentially debilitating illnesses—need this legislation. Without it, our family and countless others with similar challenges face decades of financial hardships and worse."

Sen. Kennedy said, "This is an issue that defines our humanity as a society and whether we care about fellow citizens. We, in Congress, have an opportunity with this legislation to shine a light on a dark corner of our society by making sure that we give those challenged by mental conditions the opportunity for progress and treatment."

The APA press release on the parity bills is posted on APA's Web site at <www.psych.org/pub_pol_adv/paritybillintro22703.pdf?>. ■

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parity bill is an example. Or the state's psychiatrists may want to ensure protection of the public by opposing licensure of groups lacking adequate qualifications to offer mental health services. And one of the most frequent legislative priorities for APA district branches has been blocking the totally misguided efforts of psychologists to obtain legislative authorization to prescribe medications. A significant portion of CALF's disbursements has gone to this issue.

CALF funds are used by district branches—which generally commit significant resources of their own as well—to retain additional lobbyists to work on the key issue, to mount public affairs campaigns to inform the public about the matter, to develop educational materials, to obtain legal advice, to fund phone banks and letter-writing campaigns, and to provide staff support for these efforts. The amount of funding can be substantial. The CALF process is one of the most important ways in which APA members' dues are funneled back to the district branches to support their efforts.

But this is only half the story of CALF. Sometimes the most direct path to changes in policies and practices affecting us and our patients is through the courts.

Although filing a lawsuit has become almost a stereotypical American response to practically any concern—the suit against McDonald's for failing to warn customers that its coffee was hot being probably the iconic example—a good deal of social science data suggest that the courts are less-effective agents of social change than many people think. Nonetheless, when other channels of reform are closed off, the courts may provide the only remedy.

The Pennsylvania Psychiatric Society's (PPS) suit against several health plans and mental health managed care carveouts is a good example. The suit challenges the outrageous practices of the managed care industry, which systematically obstruct patients' access to services and bleed psychiatrists, other mental health professionals, and health care facilities to death by a thousand cuts. Initiated by PPS, the suit has been supported by funding from APA, with CALF overseeing our involvement.

Last winter, the PPS won a major victory in the U.S. 3rd Circuit Court of Appeals, which held that PPS had standing to represent the interests both of its members and of its members' patients—a precedent-setting ruling *(Psychiatric News,* March 15, 2002). However, the wheels of litigation grind slowly, and the case continues on its tortuous path through the courts.

More recently, APA's Board of Trustees voted to sign on to litigation originally brought by several state medical associations against the managed care industry. Often referred to as the "RICO suit," since it is based on the federal Racketeer Influenced Corrupt Organizations Act, the action targets the practices of the largest managed care organizations in the country. APA is one of several additional organizational and individual plaintiffs that have asked to join the suit since its inception. CALF is working now with the attorneys who brought the case to use APA's involvement to maximum effect.

Sometimes, CALF is asked to support APA involvement in a variety of legal actions involving APA members, including litigation over hospital privileges, managed care panels, licensure, and the like. Unfortunately, evaluating the merits of each case—especially at the trial level, before a record has been created—is beyond APA's capacity. Were we to expend our efforts on these cases involving single individuals, with no precedential value and little impact on public policy, it would require all the resources, and more, that APA has available for its advocacy activities.

It is sometimes possible, however, for APA to provide indirect assistance, such as suggesting experts who might testify, or for us to draft letters or affidavits that speak to the general principle at issue, without getting into the facts of the case itself.

The activities of the Committee on Advocacy and Litigation Funding are one more way that APA works to improve the practice of psychiatry and the well-being of our patients. ■

association news

Grand Rounds

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and procedures that can be made error proof.

"Participants tended to think in terms of improving individual professional performance, rather than using procedures and technological processes to make it impossible for mistakes to happen," Shore said. "I kept prodding people to pay attention to protocols, such as making sure that residents don't write orders unless they are checked by a central authority.

"There were a few people who were really onto the culture of error prevention," Shore said. "These tended to be psychiatrists who were working in general hospitals where they had responsibility for programs that included other specialties."

Hales said Grand Rounds Online currently has about 300 subscribers. The volume of e-mail "traffic" has been "just about perfect," she said, with participants receiving approximately seven e-mails a day on the heaviest day.

Hales hopes to keep Grand Rounds Online slightly out on the edge, away from the topics that typically predominate at CME conferences. Future subjects for discussion include ethics and women's mental health issues.

The discussion on cultural competence ended in late February, and the next discussion will begin after APA's annual meeting in May.

Hales urges members to give Grand Rounds Online a try. "Providing continuing education is one of the core functions of a professional society," Hales said. "We are interested in developing more and better products for our members." ■

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letters to the editor

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support, and medical funding than pseudo-psychoanalysis of our nation's leadership.

ETHAN KASS, D.O., M.B.A.
Coral Springs, Fla.

Psychotherapy Backlash?

I would like to comment on the study reported in the February 7 issue in the article "Prescription Data on Youth Raise Important Questions." The graphs that accompanied the article showed a marked increase in the usage of all types of psychotropic medications.

Many issues were raised in the article, but I did not see a discussion of the fact that for many years the child psychiatry community was dominated by analytically oriented psychiatrists even more so than the adult group. These psychiatrists promoted the idea that children should not be given psychotropic drugs, and some suggested that the use of them would perhaps be developmentally harmful.

Many of us adult psychiatrists who saw an occasional child or adolescent did not follow this guideline and found that children and adolescents tolerated the medications well and benefited from them.

I recall a 14-year-old girl whom I saw about 20 years ago. She had been diagnosed with school phobia after being unable to attend school for three consecutive years and was treated with family therapy. Unbeknown to the psychiatrist treating her, her family physician had put her on an antidepressant each year, and each time after about two months she returned to school, with the psychiatrist thinking it was the result of the family therapy. Unfortunately, the medication was stopped when she returned to school. When I saw her during the fourth year, I discovered that her family had a prominent history of bipolar disease, and some family members had responded to lithium. I put her on lithium, and she was back in school in three weeks with no other form of therapy. She was kept on lithium, and her symptoms never returned; she is now a mother and schoolteacher.

What is now happening is a long-overdue catching up in prescribing psychotropics to children and adolescents. There is a greater recognition that children have the same organically and genetically caused diseases that adults have and require similar treatment.

Some may find it shocking to learn that I encountered a patient who was treated back in the 1940s at the age of 10 for a schizophrenic episode with deep coma insulin and electroconvulsive therapies by a psychiatrist a generation older than I. I saw her as a 30-year-old after she had relapsed into another clearly paranoid schizophrenic episode but was responsive enough to be controlled with antipsychotic drugs. However, the somatic therapy she had had at 10 kept her well enough for 20 years for her to complete college, marry, and have a child. Of course, there are some poorly trained physicians who may inappropriately use these drugs, but it happens with adults as well as children.

HENRY B. BRACKIN JR., M.D.
Nashville, Tenn

legal news

Inmates

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addressing a contention of the plaintiffs that inmates are often left at bus stations at all hours of the day and night.

The agreement also requires that discharge planning include an assessment of the need for medication, case management, substance abuse treatment, and psychiatric rehabilitation services. In addition, appointments for and referral to these services are to be arranged prior to discharge, and the city is to inform the inmate orally and in writing of the time, date, and place of such appointments. Within three days of such appointments, jail officials are to contact the treatment or service program to find out whether the released inmate showed up.

If continuing medication is needed, jail staff are to provide the inmate with a seven-day supply and a prescription for 21 additional medication days. If there is a reason an inmate is denied such medication, officials are to document it in writing.

The city is now also required to help inmates apply for Medicaid or, if they were on it previously, to help them get it reinstated.

The amicus brief is posted online at <www.bazelon.org/issues/criminalization/bradh.html>. The settlement of the suit is posted at <www.urbanjustice.org/litigation/PDFs/BradSettlementMHP.pdf>. ■

Courts

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in less treatment referrals than through the mental health court."

Munetz added, "Another reason our mental health court is more effective than traditional court is that there are graduated sanctions for treatment noncompliance including jail time. I believe this is necessary given that we are dealing with people who have a history of noncompliance with treatment."

He acknowledged that this creates "a tension between the defendant's voluntary entry into mental health court treatment and coercive compliance measures."

The Bazelon Center report advocates a comprehensive community mental health system to serve people with mental illnesses rather than relying primarily on mental health courts to serve that function.

Gregory Peterson, M.D., director of clinical services for Community Support Services Inc., which provides services to the local mental health court in Akron, Ohio, said, "I agree with the report that the mental health courts are not a panacea for the problems of mentally ill individuals. The courts must function in the context of a community mental health system that has the resources and the will to serve these people."

"The Role of Mental Health Courts in System Reform" is posted at <www.bazelon.org/issues/criminalization/publications/mentalhealthcourts/index.htm>. ■

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Death Row

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his arguments, he took his case to the federal appeals court.

Competing Interests Weighed

In its February ruling the appeals court weighed the competing interests of Singleton in avoiding being forced to take medication that paves the way for his execution against the government's interest in punishing offenders whose crimes are so heinous they qualify for the death penalty.

The court decided that not only does Singleton have a history of wanting to take the powerful drugs rather than remaining psychotic, but also he "has suffered no substantial side effects" from the drugs.

On these facts, the majority decided, "the state's interest in carrying out its lawfully imposed sentence is the superior one."

(The development of such side effects was part of the U.S. Supreme Court's reasoning in the 1992 *Riggins v. Nevada* case, which established limits on a state's ability to medicate a mentally ill prisoner involuntarily. States were to first seek less-intrusive alternatives and then to medicate only if the safety of the patient or others was at risk.)

The appeals court did acknowledge that there is no less-intrusive treatment for alleviating Singleton's psychosis, but that the potential side effects "do not overwhelm the benefits of the medicine."

The court also looked at Singleton's argument that while taking the medication may be in his "best medical interest," being executed is not, and it is the only "unwanted consequence of the medication."

The majority disagreed with this argument, however, saying that in this case "the best medical interests of the patient must be determined without regard to whether there is a pending date of execution," thus allowing the state to medicate him forcibly. They added that "since states have the right to interpret their constitutions as they see fit," they elected to not undertake an inquiry of the state's motives in wanting to medicate Singleton beyond its desire to provide required medical care. That is, they did not evaluate whether the state's primary motive was punitive rather than medical, which would likely be interpreted as unconstitutional.

The court's ultimate conclusion was that a state does not violate a prisoner's Eighth Amendment protections against cruel and unusual punishment "when it executes a prisoner who became incompetent during his long stay on death row but who subsequently regained competency through appropriate medical care."

Dissenting Opinion

The dissenting minority's opinion, however, emphasizes that "to execute a man who is severely deranged without treatment, and arguably incompetent when treated, is the pinnacle of what Justice Marshall [in *Ford v. Wainwright*] called 'the barbarity of exacting mindless vengeance.' "

They cited Supreme Court cases, "the overwhelming majority of scholarly commentary, and the ethical standards of the medical profession" in concluding that the majority justices' ruling was wrong.

The dissenting justices also distinguished between being cured and having symptoms masked by medication. They noted that the latter situation characterized Singleton and that no authorities claim that antipsychotics cure schizophrenia. "One of the pitfalls of equating true sanity with its medically coerced cousin," they said, "is that drug-induced sanity is temporary and unpredictable" and that the drug may affect the individual differently each time it is administered. In Singleton's case, the medications he took have never kept him free of schizophrenia symptoms, they pointed out.

Regarding the majority's refusal to examine the state's motives, the dissenting justices concluded, "At the very least, setting an execution date calls into question the state's motivation for administering the medication." Once that date was set, the argument that medicating him was in his medical interest evaporated, they maintained.

Should psychiatrists be asked to participate in these end-stage, death-penalty decisions, Zonana strongly urged them to "not feel overly pressured by state governments to do things that are personally or professionally unacceptable." ■

clinical & research news

Stem Cells

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anywhere in the body. More importantly, Prockop and colleagues have shown that MSCs can be extracted from bone marrow and grown in the laboratory rapidly and in enormous numbers.

"You can grow them in culture and make billions of them," he explained.

By injecting the multiplied MSCs into the site of a lesion, Prockop and his colleagues hope to enhance the brain's natural production of stem cells and thereby enhance repair and restoration of function—a vision that has been realized in animal studies.

In a study published in the February 19, 2002, *Proceedings of the National Academy of Sciences*, researchers in Prockop's laboratory exposed the spinal cord of a rat to injury, paralyzing the animal's hind limbs and lower body. MSCs, grown in exponential numbers in the laboratory, were then injected into the site of the injury. "One week after the injury, motor function improved dramatically," Prockop told *Psychiatric News*.

The regulatory and scientific hurdles to be overcome are many before stem cell therapy will be a reality, but scientists are enthusiastic. Prockop believes the most likely first use of stem-cell therapy will be to repair spinal-cord injury.

And he does not rule out the potential for treating Alzheimer's, Parkinson's, and other neurodegenerative diseases. In the most visionary formulation of the new field, some scientists have spoken of using stem cells as a veritable "fountain of youth" for the brain.

Providing psychiatrists an overview of the new science during the 2001 APA annual meeting in New Orleans, Prockop underscored the stunning nature of the possibilities inherent in the field.

"I cannot prove that we can use the marrow as the equivalent of a fountain of youth, but we are moving close to that possibility," he stated at the meeting. "Now is the time for us to seriously debate it and discuss the consequences of where the science is moving. We need to discuss this not only among scientists but also among physicians and the lay public." ■

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LILLY SYMPS
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Cholesterol

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populations involving 201 patients with Alzheimer's and 248 control subjects. Subjects who carried the CYP46-TT polymorphism were 2.2 times more likely to have LOAD than those who were CYP46-TT negative, while those who were positive for APOE-E4 were 4.4 times more likely to be diagnosed with LOAD. Subjects carrying both polymorphisms were 9.6 times more likely to have LOAD.

Papassotiropoulos and his coauthors concluded that not only is CYP46-TT a novel genetic risk factor for LOAD that warrants further study in larger populations, but that the polymorphism works in a synergistic way with APOE-E4 to increase risk for the disease drastically.

In an editorial accompanying the report by Papassotiropoulos, Benjamin Wolozin, M.D., Ph.D., associate professor of pharmacology at Loyola University Medical Center, noted that the CYP46-TT linkage to Alzheimer's "integrates comfortably with the model of LOAD based on regulation of Aß production by cholesterol." Wolozin also says that the CYP46-TT study may work to focus attention on the "potential importance of cholesterol metabolism in LOAD." The results, he wrote, "suggest the possibility that LOAD, the most common degenerative disease of the brain, is a general end point for abnormalities that increase the amount of cholesterol in the central nervous system. If so, inhibiting cholesterol metabolism in the brain might represent a viable treatment for LOAD."

An abstract of "Increased Brain ß-Amyloid Load, Phosphorylated Tau, and Risk of Alzheimer Disease Associated With an Intronic CYP46 Polymorphism" is posted on the Web at <http://archneur.ama-assn.org/issues/v60n1/abs/noc20166.html>. ■

Twin Study

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that could potentially influence whether a person decides to use marijuana or other drugs later in life.

What are the factors that link early marijuana use to more serious drug problems down the road? Early experiences with marijuana are often pleasurable, the researchers posited, and so youngsters may be likely to replicate the pleasurable experience with more marijuana use or the use of other drugs.

They may also have had "safe" experiences—that is, their parents or law enforcement officials did not discover the youngster's marijuana use. This "may reduce the perceived risk of, and therefore barriers to, the use of other drugs," according to the report.

In addition, when youngsters begin using marijuana at an early age, over time they may have increased exposure to drug dealers and other drugs.

This theory, Lynskey pointed out, "is often used to support sanctions against cannabis, but also has been used for state decriminalization of cannabis." He noted that government officials in the Netherlands, acting on the assumption that marijuana serves as a gateway to drug dealers and thus harder drugs, legalized marijuana so that people would have less contact with these other drugs in their pursuit of marijuana.

Although the association between early marijuana use and later drug use and abuse emerged in the study findings, Lynskey emphasized that "the majority of those who use cannabis at an early age did not go on to abuse or become dependent on other drugs."

Although Lynskey said he believes the findings from the twin study can be generalized to populations in the United States and other places in the world, he would like to see the study replicated elsewhere to "focus on the mechanisms underlying the association between early cannabis use and that of other drugs" and protective factors in early cannabis users who do not develop drug abuse or dependence.

An abstract of the study, "Escalation of Drug Use in Early-Onset Cannabis Users vs. Co-Twin Controls" is posted on the Web at <http://jama.ama-assn.org/issues/v289n4/abs/joc21156.html>. ■