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Psychiatric
Association

PSYCHIATRIC NEWS

Association News

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APA Calls for Budget Increase For Mental Health Institutes

Members of APA's Academic Consortium meet with their congressional representatives in Washington, D.C., to persuade them that the National Institutes of Health deserves a 10 percent increase in Fiscal 2004.

BY CHRISTINE LEHMANN

With the war on Iraq hanging over the nation last month, members of APA's Academic Consortium urged their legislators on Capitol Hill to avoid making biomedical research a war-time funding casualty.

President Bush proposed only a 2 percent increase in the Fiscal 2004 budget for the National Institutes of Health, which is a sharp contrast to his Fiscal 2003 proposed budget increase of 16 percent, which Congress approved. APA and the Ad Hoc Group on Medical Research Funding played a role in nearly doubling the NIH budget between 1998 and last year and are advocating for a 10 percent increase in Fiscal 2004 to sustain that effort.

Bush proposed a budget increase of between 3 percent and 4 percent for the National Institute of Mental Health (NIMH), National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), according to an APA Fiscal 2004 appropriations summary. Last fiscal year, Bush proposed between an 8 percent and 9 percent increase for each institute.

The NIMH is the primary source of research grants for psychiatrists who conduct mental health research at their local institutions, said APA President Paul Appelbaum, M.D., in an interview with *Psychiatric News*.

The NIMH last year reported a $1.3 billion research budget that provides support to investigators at universities in the areas of basic science, clinical research, including large-scale trials of new treatments, and studies of the organization and delivery of mental health services, according to a press release from NIMH.

Speakers at APA's consortium—including co-chairs Lewis Judd, M.D., David Kupfer, M.D., and Appelbaum—complained that the president's proposed Fiscal 2004 increases for NIMH, NIDA, and NIAAA barely kept up with inflation and would jeopardize funding of current and new research grants.

This year's consortium was attended by slightly more than 40 people including representatives of the National Alliance for the Mentally Ill, American College of Neuropsychopharmacology (ACNP), and Amer-

please see ***Budgets*** *on page 13*

SFCVB photo by Bob Ecker

The vibrant color and culture of San Francisco's Chinatown is but one attraction of APA's 2003 annual meeting this month. APA members and their guests can register on site for the meeting and CME courses. See related articles on pages 28 to 32.

Clinical & Research News

New Drug Offers Hope As Alzheimer's Treatment

Alone, and in combination with cholinesterase inhibitors, memantine shows promise for patients with advancing Alzheimer's disease.

BY JIM ROSACK

Two new studies suggest that memantine, an investigational new drug for the treatment of moderate to severe Alzheimer's disease, appears to significantly improve cognitive function as well as patients' ability to perform everyday tasks like dressing themselves, bathing and toileting, and eating.

Memantine, currently under review by the Food and Drug Administration, targets a different chemical pathway than the existing medications approved to treat Alzheimer's disease. The drug blocks the binding of glutamate—the brain's primary excitatory neurotransmitter—to N-methyl-D-aspartate (NMDA) receptors.

It is thought that glutamate plays a significant role in the neuronal cell death that is common to all neurodegenerative diseases. As neurons are damaged—in Alzheimer's, for example, by the deposition of amyloid—that damage leads to an excess release of glutamate, which neuroscientists refer to as "overexcitation."

High levels of glutamate can drastically alter the cell's internal levels of calcium, leading to toxicity and cell death. By blocking the action of glutamate at NMDA receptors, the drug directly short-circuits that "over-excitation."

The two recent studies include data from two separate clinical trials of the drug, presented at the annual meeting of the American Academy of Neurology last month, expanding on a report in the April 3 *New England Journal of Medicine (NEJM)*.

Memantine, studied as a single therapeutic medication in the first trial, slowed both the mental and physical deterioration of patients with moderate to severe Alzheimer's, according to Barry Reisberg, M.D., a professor of psychiatry at New York University School of Medicine and principal investigator of the study. Reisberg was the lead author on the *NEJM* report and updated those data during a presentation at the neurology meeting.

"The patients we studied were all functional stage six in Alzheimer's," Reisberg told *Psychiatric News*. "They are having problems with putting on their clothes, they can no longer handle the mechanics of bathing and toileting, and eventually they deteriorate further, becoming incontinent."

Patients who were assigned to receive memantine, Reisberg noted, "seem to be declining much less, about half as much as

please see ***Alzheimer's*** *on page 55*

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Legal News

Court Hands HMOs Defeat in 'Any Willing Provider' Ruling

A unanimous decision by the U.S. Supreme Court recognizes the right of states to mandate health plans to enroll "any willing provider." However, physicians who wish to enroll must still agree to the plans' terms with regard to patient care and fees.

BY MARK MORAN

Health plans must open their panels to any and all qualified clinicians when mandated to do so by state "any willing provider" laws, according to the U.S. Supreme Court.

The unanimous ruling, issued last month in the case *Kentucky Association of Health Plans v. Miller*, would appear to strike at a central cost-containment strategy of health maintenance organizations: By limiting the number of enrolled clinicians, the plans can ensure those clinicians who are enrolled will have a sufficient patient load to compensate for discounted fees.

Approximately half the states have laws that inhibit that strategy by requiring plans to hire "any willing provider (AWP)."

The Supreme Court's ruling revolved around whether AWP laws are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), which preempts all state laws regarding employer-provided health plans.

ERISA's preemption provision, however, also contains an exception for state laws that "regulate insurance, banking, or securities." So the legal question in the case was whether an AWP law constitutes a regulation of insurance.

The Kentucky Association of Health Plans argued that Kentucky's law did not regulate insurance—and was therefore preempted by ERISA—because it did not regulate the terms of insurance contracts themselves.

The Court disagreed. "We have never held that state laws must alter or control the actual terms of insurance policies to be deemed laws which regulate insurance; it suffices that they substantially affect the risk-pooling arrangement between insurer and insured," wrote Justice Anthony Scalia for the Court. "By expanding the number of providers from whom an insured may receive health services, AWP laws alter the scope of permissible bargains between insurers and insured. . . . No longer may Kentucky insureds seek insurance from a closed network of health care providers in exchange for a lower premium. The AWP prohibition substantially affects the type of risk-pooling arrangements that insurers may offer."

The decision was applauded by the AMA, which along with APA and three other medical groups, filed a friend-of-the-court brief in support of the state's right to regulate health plans through any willing provider laws. The other groups were the Kentucky Medical Association, National Medical Association, and American College of Obstetricians and Gynecologists.

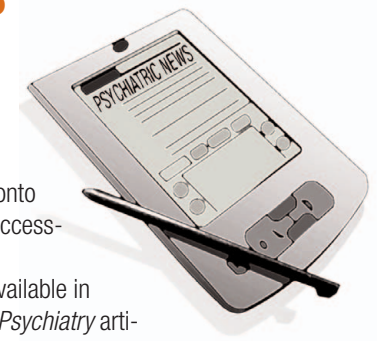
"The American Medical Association believes that the U.S. Supreme Court today provided patients and physicians with a major victory when they issued a rare unanimous decision in *Kentucky Association of Health Plans v. Miller*," said AMA President-elect Donald Palmisano, M.D. "The AMA believes this victory adds clarity to patient protections established by state lawmakers against the abuses of managed care."

Palmisano noted that the brief filed by the AMA, APA, and the other organizations "also emphasized the need to take a fresh look at a more useful method for analyzing

please see ***Ruling*** *on page 56*

Association News

APA Publications to Go



APA members can now hold *Psychiatric News* and the *American Journal of Psychiatry* in the palm of their hand.

Last month APA activated a new service through which members can download the two publications onto their Palm OS personal digital assistants (PDAs) by accessing HighWire Press.

The full text of *Psychiatric News* articles will be available in this format, as will abstracts of *American Journal of Psychiatry* articles. (Full research articles from the journal are too long to display on PDAs.)

Members who are interested in having such anywhere, anytime access to the newspaper and the journal need to download the HighWire Remote software and then configure their HighWire accounts to work with their PDA. APA and HighWire are evaluating whether the demand by members justifies expanding the service to PDA platforms other than the Palm OS.

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How Are We Doing?

BY PAUL APPELBAUM, M.D.

Erstwhile New York City mayor Ed Koch, a compulsive extrovert, used to pump the hands of prospective voters wherever he could find them and ask, "How'm I doin'?" Whatever led Hizzoner to reverse the usual social convention (most of us, after all, ask the people we meet, "How are you doing?"), the impulse to take stock of one's performance can be a positive one for both people and organizations. With my year as APA president soon coming to an end, it seems like an appropriate time to ask "How is APA doing?"

In many ways, APA is doing very well indeed. From a financial perspective, after two deficit years in 1999 and 2000, APA finished in the black in 2001 and will show an excess of revenues over expenses of more than $1.2 million for 2002. In part, the turnaround is due to striking increases in revenue from our income-producing activities, including the publishing business of American Psychiatric Publishing Inc., our subsidiary and the largest psychiatric publisher in the world. Moreover, dues income markedly exceeded expectations, as the decrease in membership leveled off and more members paid up back dues.

Of course, even a strong performance on the revenue side can be dissipated by profligate spending. That is precisely what did not happen in 2002. The Board and the medical director worked together to hold the line on expenditures and to identify economies at every level of the organization. Nonessential staff positions were held vacant, and administrative reorganization allowed reductions in the ranks of management. A complete reorganization of our council and committee structure, implemented this past fall, trimmed the number of components and maximized the use of new communication technologies in lieu of expensive face-to-face meetings. And our newly created Financial Oversight Committee meets monthly by conference call to make sure things stay on track.

Despite the strong performance this year, we are not entirely out of the woods yet. Structural factors in the APA budget mean that 2004 will be another tight year—although hopefully the last in which we begin budget planning with a multimillion dollar gap to close. The Board has rejected

please see ***From the President*** *on page 59*

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VA Accused of Shortchanging Substance Abuse Treatment

When the VA adopted managed care techniques in its health care system, substance abuse treatment was one of the biggest casualties.

BY KATE MULLIGAN

In 1996, through PL 104-262, Congress mandated that the Department of Veterans Affairs (VA) maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans.

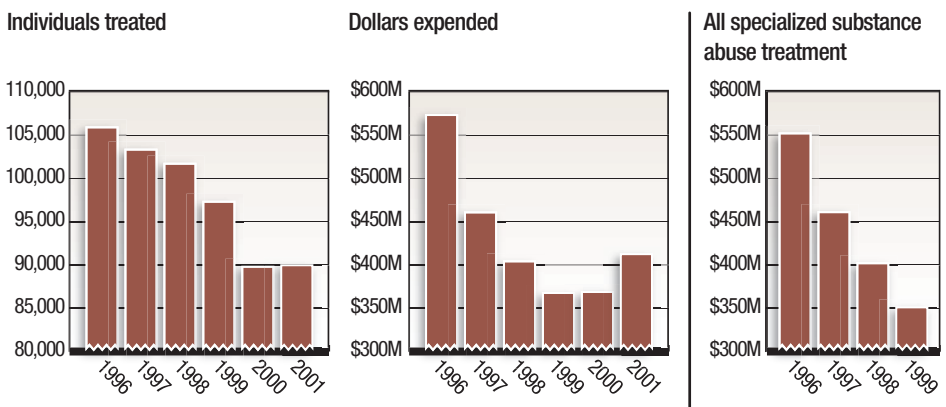
The legislation came about because the VA was moving to a capitation model of distributing funds throughout its health care system. Advocates and others were concerned that veterans with costly illnesses and disabilities might be shortchanged because of the cost advantage in treating other kinds of patients.

Each year since then, the Committee on the Care of the Seriously Mentally Ill (SMI committee), which Congress mandated to monitor and advise on the care of the groups specified in the legislation, and the VA have disagreed about whether the VA has maintained capacity for veterans with serious mental illness *(Psychiatric News*, February 7).

Both the committee and the VA agree, however, that capacity for substance abuse treatment has not been maintained.

Decline in Numbers and Money

Two separate studies find that capacity for treatment of substance abuse has not been maintained at the VA.



Source: Veterans Affairs Administration, Fiscal Year 2001 Capacity Report

Source: "The Effect of Reforms on Spending for Veterans' Substance Abuse Treatment, 1993-1999," *Health Affairs,* July/August 2001

Data found in the FY 2001 Capacity Report (released October 2002) show a decline in the number of individuals treated for substance abuse and in the dollars spent (see charts above).

In "The Effect of Reforms on Spending for Veterans' Substance Abuse Treatment, 1993-1999," in the July/August 2001 *Health Affairs*, Shuo Chen, Todd Wagner, and Paul Barnett examined the effect of these trends.

The authors are, respectively, research associate at the Health Economics Resource Center (HERC), Veterans Affairs Palo Alto Health Care System; health economist at HERC; and director of the HERC.

The authors noted that the VA, which provides health care to more than 3 million veterans, is the nation's largest provider of substance abuse treatment.

They claimed that "spending for VA substance abuse treatment declined precipitously from 1993 to 1999." Their figures, while somewhat different from those in the capacity report, also show a decline. And, they noted, "While total spending for VA health services rose 10 percent between 1993 and 1999, the amount spent on substance abuse treatment declined by 41 percent."

The most dramatic change, however, was similar to that which took place in the mental health system as a whole during the same period.

Chen and colleagues wrote, "The VA sought to expand the number of veterans served by 20 percent and to decrease the average per-patient expenditures by 30 percent [over a five-year period]."

Managed care was to bring about the transformation. According to information in the August 2002 *Psychiatric Services*, "By October 2000, inpatient substance abuse treatment beds were almost eliminated at VA facilities. The number of residential beds more than doubled from 1994 to 2000, but this increase was not enough to fully offset the 91 percent decrease in inpatient substance abuse beds."

The net result of the two trends, according to the authors, is a system that is about half the size of the former system and that has moved from relying primarily on medical inpatient beds to relying almost exclusively on lower-cost residential beds in nonmedical settings.

Opinions vary about the results and implications of these changes. Chen and colleagues wrote that although the number of patients who received specialized substance abuse treatment changed little between 1993 and 1999, they accounted for a "dwindling proportion of all VA patients," since the total number of persons receiving health care in the VA increased greatly, from 2.7 million in 1993 to 3.4 million in 1999.

Larry Lehman, M.D., chief consultant for mental health services at the VA, agreed

please see ***Substance Abuse*** *on facing page*

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VA Must Increase MH Funds, To Meet Needs, APA Tells Congress

APA advocates for increased funding and services for veterans with mental health and substance abuse problems.

BY CHRISTINE LEHMANN

Veterans with mental health and substance abuse problems are not receiving the high-quality services to which they are entitled, and APA is demanding change.

Former APA president Joseph T. English, M.D., testified last month before the House Appropriations Subcommittee on Veterans Affairs and Housing and Urban Development.

"The number of veterans needing mental health services has increased 26 percent between 1995 and 2001, but during that time relevant programs have been cut 4 percent, the per-patient expenditure has been cut 24 percent, and the average inpatient length of stay has decreased almost 24 percent," said English, chair of the department of psychiatry and behavioral sciences at St. Vincent's Catholic Medical Centers of New York.

Parity for mental health and substance abuse services does not exist in the VA (see article on page 4), said English, who is also professor and chair of the department of psychiatry at New York Medical College. English noted that the college is affiliated with two New York VA medical centers.

"Despite the increase in the numbers of patients with substance use disorders, the number of substance-use programs dropped by 37 percent—from 386 to 243—between 1994 and 2000," said English.

Because veterans often have comorbid conditions, that is, mental and other medical problems, English recommended that the VA invest in programs that use a continuum of care that includes intensive case management, psychosocial rehabilitation, peer support, and integrated treatment of mental and substance use disorders. "This continuum should also include housing alternatives, compensated work therapy, and other support services for veterans with serious mental illnesses," he said.

Although valuable programs such as the Mental Health Intensive Case Management and Compensated Work Therapy exist, "they reach only a small number of patients who need their services," said English.

"The VA estimates that out of 561 such programs, 265 have failed to provide any mental health services. There are also rigid restrictions on medication use and on new and sometimes more expensive drugs that the patient's condition requires but can be denied in the patient's treatment," said English.

APA applauded the VA's inclusion of $52 million in its budget to enhance and expand services for homeless veterans, English testified. "APA also applauded the VA for initiating the program for Psychiatric Primary Care Education [PsyPCE], which allows psychiatry residents to assume the duties of primary care physicians for mentally ill patients in mental health and primary care settings," said English. "However, it is important that the VA continue its core psychiatric residency and fellowship training capabilities."

APA also recommended that the VA increase funding for the Mental Illness Research, Education, and Clinical Care Centers (MERECCs) and fund two new centers in Fiscal 2004.

Written testimony submitted by English on behalf of APA to the VA subcommittee is posted on the APA Web site at <www.psych.org/pub_pol_adv/increasefund4vet.cfm>. ■

Substance Abuse

continued from facing page

that the number of patients receiving specialized care for substance abuse has not kept pace with the increase in the number of veterans receiving care. He added, however, that the recent "surge" in patients was accounted for by those in priority groups 7 and 8, who, for the most part, do not use VA substance abuse care.

He also told *Psychiatric News* that the capacity report summarizes only those expenditures for substance abuse patients treated in specialized substance abuse programs who meet the criteria for "serious mental illness." According to Lehman, "Expenditures for the treatment of all substance abuse patients, whether in specialized programs or not, has not gone down. Almost all acute inpatient care for substance abuse patients takes place in nonspecialized settings."

According to Chen, there is evidence that patients entering specialized VA substance abuse programs are "sicker than ever." Between 1990 and 1997, the proportion of people in those programs with a comorbid psychiatric diagnosis increased from 29 percent to 40 percent.

Lehman responded to *Psychiatric News* that the increase could also represent a "significant improvement in diagnostic accuracy." From 1989 to 1995, the VA undertook an initiative to diagnose and treat comorbid disorders.

Finally, according to the August 2002 *Psychiatric Services*, "the proportion of substance abuse treatment programs that had patients on waiting lists rose from 68 percent to 75 percent for inpatient programs and from 58 percent to 80 percent for residential programs."

Former APA President Joseph T. English, M.D., testified before the House Appropriations Subcommittee on VA-HUD and Independent Agencies on VA appropriations for Fiscal 2004 (see article above).

English also urged continuation of the VA Substance Abuse Fellowship Program as a means of ensuring a well-trained professional workforce that can implement new treatment knowledge. ■

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Depression Education Campaign Looks Beyond Machismo

About 6 million men in the United States suffer from depression annually, but most don't seek professional help. To change that situation, a federal mental health agency launches a public-education campaign on depression aimed at men.

BY CHRISTINE LEHMANN

Jimmy Brown, a firefighter from New York, describes the despair and mental anguish he endured during his recent struggle with major depression. He is one of eight men whose stories of overcoming depression are featured in a new public awareness campaign sponsored by the National Institute of Mental Health.

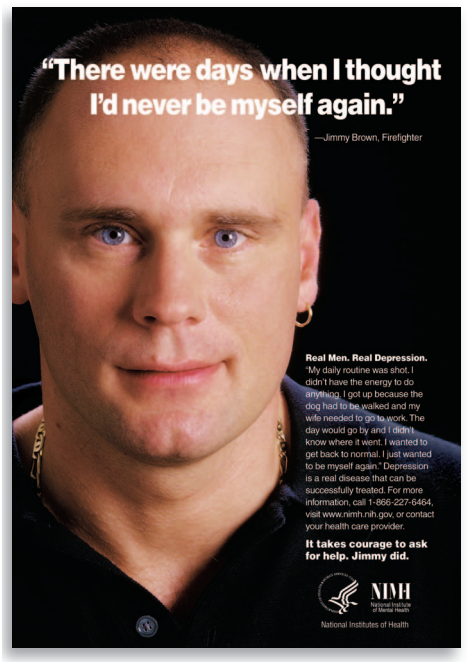
NIMH announced its "Real Men, Real Depression" campaign last month at the National Press Club in Washington, D.C. NIMH and a documentary filmmaker produced a series of public service announcements that were sent to major television and radio stations and newspapers nationally.

Although women who are depressed are more likely than men to attempt suicide, men who are depressed are four times more likely than women to commit suicide, according to the NIMH.

A common misconception held by the eight men who described their struggles with depression for the NIMH campaign was that the symptoms eventually "disappeared" without treatment.

NIMH Director Thomas Insel, M.D., said at the press briefing, "Men don't seek treatment for three main reasons. They may not recognize the signs of depression, which include feeling hopeless, helpless, and worthless. Their experience of those symptoms interferes with help seeking, and men are concerned that others will view them as weak."

U.S. Surgeon General Richard Carmona, M.D., said at the press briefing, "Being a former soldier, paramedic, trauma surgeon, and police officer, I have worked on the edge of life and death. As a paramedic and police officer in particular, I saw that my colleagues struggled but didn't know where to turn for help because everyone came to them for help. They were viewed as the pillars of their communities and families."



A poster from the NIMH campaign *"Real Men, Real Depression,"* featuring firefighter Jimmy Brown.

Macho Professions Affected

Some of the men in the NIMH campaign served in the police and military. They said that a major barrier to seeking help was the stigma in their workplaces surrounding having psychological problems.

Brown said that he kept his bouts with depression a secret during his military and police experiences and the first part of his firefighter career. "In the Marines, you don't want to give anyone a reason to doubt your ability to perform in combat situations."

In the New York Police Department, the stigma was even greater, and "you became the butt of jokes," said Brown.

His coping mechanisms crumbled after nearly being killed by the collapse of the North Tower of the World Trade Center on September 11, 2001. "I worked at the firehouse across from the World Trade Center, and it was still standing the next day, so I returned to work. I was flooded with daily reminders of the vast destruction and became very anxious and resumed smoking and started drinking more heavily," said Brown.

After the fire department counseling services denied his request for a temporary transfer, he asked for a leave of absence, which was granted. "That was probably the worst thing because I had nothing but time on my hands and fell into a deep depression," said Brown.

"Since the fire department couldn't help me out, I turned to a police peer-support group I had been involved in when I was a police officer. Through that, I was referred to a clinician and saw him over a few months. I began recovering and was able to return to work," said Brown.

Other men in the campaign ads described how they were affected by depression. One flirted with death by driving recklessly, another became drunk on a regular basis to numb the psychic pain, at least a few considered suicide, and one attempted suicide.

Reducing Suicide Risk

Shaun Colton, 26, a championship diver and a student from Clarion, Pa., told *Psychiatric News* at the National Press Club event that he attempted suicide when he was attending college in Houston. "I stopped feeling happy and had no desire to

please see ***Depression*** *on page 17*

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Factors Collide to Increase Suicide Risk in Elderly

Americans aged 65 and older have the highest suicide rate of any age group. Preliminary results of a new controlled study of suicide show several risk factors play a role.

BY CHRISTINE LEHMANN

People over age 65 have the highest suicide rate of any age group. Preliminary results from the first psychological autopsy study of completed suicides in the United States suggest that a combination of factors pushes them over the edge.

Researchers at the University of Rochester Center for the Study and Prevention of Suicide in Rochester, N.Y., studied 86 people who completed suicides in nearby Monroe and Onondaga counties. The mean age of the group was 68. A control group was matched by age, sex, race, and county of residence. The majority of both groups were Caucasian, and men outnumbered women 3 to 1.

"Our preliminary findings suggest that mood disorders—in particular major depression—previous suicide attempts, physical illnesses or decline, and loss of social support are significant risk factors for suicide in the elderly. We believe our final analysis will show that the balance is tipped toward suicidal behavior in the elderly when two or more of these factors collide" (see chart), said lead researcher Yeates Conwell, M.D., in an interview with *Psychiatric News*.

Conwell codirects the suicide study and prevention center with Eric Caine, M.D., chair of the department of psychiatry at the University of Rochester. Conwell is also associate chair for academic affairs in the department of psychiatry there.

The researchers worked with the medical examiner's office to identify persons who had committed suicide and then contacted the next-of-kin for informed consent. If consent was given, "we obtained the individual's autopsy report and medical and psychiatric records and interviewed family members, friends, and health care providers," said Conwell.

The researchers constructed individual profiles using several measures including a suicide behavior profile, structured clinical interview for psychiatric diagnoses, a life-events profile, a health history, and tests to determine functioning, said Conwell.

The researchers found that 73 percent of the 86 people who died by suicide had a mood disorder, and 50 percent had one or more episodes of major depression. In the control group, only 9 percent had a mood disorder, and 5 percent had a major depressive episode.

Nearly 34 percent of the group who had died by suicide had a substance use disorder, compared with half that percentage in the control group, said Conwell.

"A study by my co-investigator Paul Duberstein, Ph.D., in the August 1994 journal *Psychiatry* showed that people who committed suicide later in life often had neurotic personality traits, more rigid cognitive processes, and limited coping skills," said Conwell.

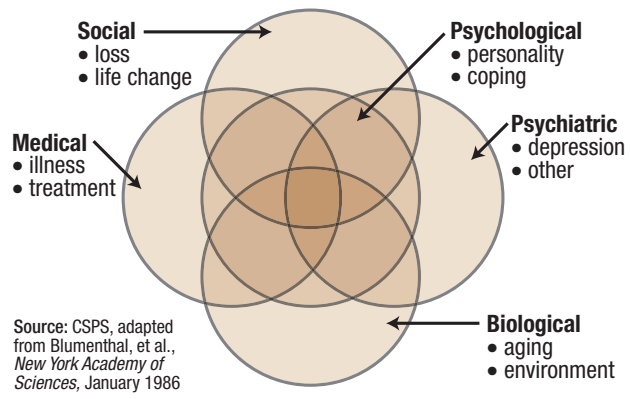
Neurotic personality traits, such as a tendency to feel anxious and depressed, can tip the balance toward suicide when adverse life events occur simultaneously, he added.

The elderly who completed suicide had more physical illnesses and impaired daily functioning than their matched controls, said Conwell. "We found that they also participated in social activities less often than the control group," he said.

"We know from epidemiological studies that men are three to four times more likely to commit suicide than women during their lifetimes. White men over the age of 85 have nearly three times the risk of suicide as white men at or below age 60, while white women experience a slight decline in suicides after age 5," said Conwell.

"In most other countries, the suicide rate of women continues to increase steadily after midlife, although at a much slower rate than that of men. What then protects women from completing suicide as they age? Possible clues are that they use less lethal means in the suicidal act than men, who favor handguns, and they are more likely to forge confidential, supportive relationships with others," said Conwell.

Domains of Suicide Risk in Later Life



Source: CSPS, adapted from Blumenthal, et al., *New York Academy of Sciences*, January 1986

Suicide acts are more likely to result in death among the elderly in general than among younger individuals for many reasons, according to Conwell. "Their physical condition is more frail, which impairs

please see ***Suicide Risk*** *on page 60*

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Medical Marijuana Movement Notches Several Victories

Two states move closer to legalizing medical marijuana, while court battles in two other jurisdictions end with favorable verdicts for legalization proponents.

BY JIM ROSACK

Legislatures in Vermont and Maryland have moved toward legalizing the medical use of marijuana. In addition, recent legal challenges in two jurisdictions have ruled in favor of the controversial use of marijuana for patients with cancer, HIV/AIDS, and other debilitating illnesses.

In Vermont, the state Senate in March passed a comprehensive measure legalizing and tightly controlling the cultivation and use of marijuana by patients. The Vermont Psychiatric Association (VPA) has actively supported the effort to legalize marijuana for specific purposes under significant controls and restrictions.

"The VPA took this position because we felt that decisions about health care should remain between individuals and their physicians," noted VPA public affairs representative David Fassler, M.D., who is also an APA trustee-at-large. "In general, we are wary about government intrusion into the practice of medicine. We realize that the use of marijuana for medical purposes remains controversial. Yet, many of the treatments we use in medicine today are controversial. We are concerned, however, when these issues get overly politicized. In general, that isn't a good way to make public policy."

In December 1997, APA published a position statement emphasizing that "while adequate research evidence is lacking at this time to support the medicinal use of marijuana, there is clinical experience claiming potential usefulness of marijuana in patients with AIDS and other debilitating conditions, such as for symptoms of pain and vomiting, promotion of weight gain, and reduction of intraocular pressure."

The position statement notes that research to substantiate these claims should be expedited and concludes that marijuana should be approved for medical uses and controlled as a Schedule II drug under the provisions of the Controlled Substances Act.

Currently, marijuana is a Schedule I substance, defined as having a high potential for abuse and addiction and no accepted medical uses.

However, in 1999 the Institute of Medicine, at the request of the White House Office of National Drug Control Policy, reviewed the scientific evidence on the medical use of marijuana and found that "scientific data indicate the potential therapeutic value of cannabinoid drugs for pain relief, control of nausea and vomiting, and appetite stimulation." It recommended strictly controlled and defined clinical trials of marijuana and the multiple cannabinoid compounds that are found in the plant.

Vermont Sees Medical Value

Supporters of legalizing the medical use of marijuana in Vermont agree, arguing that marijuana simply shouldn't be listed as a Schedule I drug.

A report by the Vermont State Legislative Medical Marijuana Study Committee released last December described 13 findings. The first finding was "there is medical value in using marijuana to ameliorate some symptoms associated with severe illnesses and the treatment thereof." That finding alone, the report noted, contradicts the requirements for placing a drug in Schedule I. Another finding states that "marijuana is misclassified by the federal government as a Schedule I drug and should be reclassified to permit physicians to prescribe and pharmacies to dispense medical marijuana."

Both the Vermont Attorney General's Office and the state's attorney endorsed those two findings. The remaining findings describe a potential system for distribution and control of medical marijuana and were generally endorsed, with some amendments, by both offices.

The Vermont bill, S 76, passed the state Senate in March. A similar bill passed the state House last year and is awaiting reintroduction. The new law would require patients who want to use medical marijuana to register with the state and to be certified by a physician as having one of a short list of specified conditions. A panel of three physicians set up by the Vermont Department of Health would decide whether a patient is eligible under the program.

If eligible, a registered patient or his or her registered caregiver would be allowed to grow and possess a limited amount of marijuana. The plants and any marijuana for consumption would have to be secured, and both patients and caregivers would be issued identification cards. Consumption of marijuana would be strictly limited to the patient's residence.

Howard Dean, a former Vermont governor who is a physician and candidate for the Democratic nomination for president of the United States, strongly opposed the measure, as does his successor, Gov. James Douglas, who cites law-enforcement concerns.

Action in Other States

In Maryland, during the same week the Vermont bill passed, state delegates gave preliminary approval to a measure that would essentially decriminalize the use of

please see ***Marijuana*** *on page 12*

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LILY SYMPOS
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P4C

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HIPAA Rules Fail to Clarify Role of *DSM-IV* Criteria

The final federal rule on electronic transmission of health care claims and other information doesn't state whether *DSM-IV* criteria for mental health and substance abuse disorders can be used for Medicare claims.

BY CHRISTINE LEHMANN

The final federal rule for transmitting Medicare claims and information electronically has created uncertainty for psychiatrists and organizations providing mental health and substance abuse services. Health care professionals must comply with the final rule by October 16.

The final rule, published in the February 20 *Federal Register*, implements specific administrative simplification provisions of the 1996 Health Insurance Portability and Accountability Act (HIPAA). According to a legal analysis commissioned by APA last year, the 1996 law appears to allow only one designated medical diagnostic and procedure set.

"Our concern is that health care professionals will be allowed only to use the ninth edition of the *International Classification of Diseases–Clinical Modification (ICD-9-CM)* for mental and substance abuse disorders. The *ICD-9-CM* was published about 24 years ago and is completely outdated," Darrel Regier, M.D., M.P.H., told *Psychiatric News*. He is the executive director of the American Psychiatric Institute for Research and Education and director of APA's Division of Research.

APA has asked the Office of General Counsel in the Department of Health and Human Services to review the legal analysis and its recommendation that health care professionals be allowed to continue to use *DSM-IV* criteria for electronic transactions involving mental and substance abuse disorders, said Regier.

"The *DSM-IV* diagnostic criteria have been used informally to define *ICD-9-CM* diagnostic code numbers since 1980 when *DSM-III* was first adopted. Using *DSM* instead of the *ICD-9* glossary of disorder definitions has been approved by the National Center for Health Statistics [NCHS] of the Centers for Disease Control and Prevention for over 20 years, and the *DSM-IV* criteria are designated in the draft of *ICD-10-CM* as the appropriate definitions of their diagnostic codes," said Regier.

He continued, "However, the *ICD-10-CM* is not expected to be adopted in the United States until 2006 at the earliest. This means that the *ICD-9-CM* glossary would be the default official diagnostic criteria for mental disorders when [the rule] goes into effect in October."

APA testified on the issue twice last year before the National Committee on Vital and Health Statistics Subcommittee on Standards and Security.

"We are still waiting as of March 31 for the general counsel to respond. The Center for Mental Health Services and NCHS share our concerns," said Regier.

The text of the electronic transactions and code set rule is posted on the CMS Web site at <www.cms.hhs.gov/hipaa/hipaa2>. Also posted is the final rule for security standards regarding electronic transactions. Health care professionals have until April 21, 2005, to comply with that rule. ■

Marijuana

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marijuana for medical purposes by significantly reducing the penalties for possessing or using the drug. A similar bill was awaiting action in a Maryland Senate committee in late March.

Maryland Gov. Robert Ehrlich Jr. (R) has indicated that he could support the bill, which would cap the penalty for possession or use of marijuana at $100, with no possibility of jail time.

In essence, the bill gives judges the ability to consider "medical use of marijuana as a mitigating factor," and proponents of the measure hope that judges would simply throw out charges brought against a patient using marijuana for medical purposes.

Last year, residents of the District of Columbia won a suit in federal district court after Congress attempted to stop a ballot initiative allowing residents to vote on legalizing medical marijuana. The court said that Congress—which has jurisdiction over D.C.—had overstepped its authority, infringing on residents' right to self-determination. Since that ruling, D.C. residents have not voted on such an initiative

Last fall, a federal appeals court in San Francisco ruled that the federal government may not revoke the licenses of doctors who recommend marijuana to their patients. The ruling upheld a five-year-old district court decision in California responding to the federal government's threat to revoke the DEA licenses of physicians who recommend marijuana to patients. The appeals court decision indicated that the federal government's policy interfered with the First Amendment right of free speech, in this case between physicians and their patients.

Alaska, Arizona, Colorado, Hawaii, Maine, Nevada, Oregon, and Washington state also have enacted medical marijuana laws. ■

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Budgets

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ican Association of Chairmen of Departments of Psychiatry (AACDP). This was the first time the ACNP and the AACDP were officially represented at the consortium.

Appelbaum told *Psychiatric News* at the consortium that he was concerned the president's proposed budget for NIMH would further deter new clinical researchers from entering academia. "If the federal funding pipeline dries up, clinicians will view academic research careers as too risky financially to undertake especially when they have outstanding medical school debts and other financial obligations," he said.

Judd and Kupfer exhorted consortium members to emphasize to their legislators on Capitol Hill the tremendous contribution NIH funding has made in translating research advances into psychiatric treatment. Kupfer reminded them to mention their own research projects and to contact their legislators throughout the year. ■

Reps. Susan Davis (D-Calif.) and Gary Miller (R-Calif.) pose with psychiatrist Lewis Judd, M.D. (left), co-chair of APA's Academic Consortium.

Rep. Rush Holt (D-N.J.) talks with Renee Binder, M.D. (left), chair of APA's Committee on Judicial Action, and APA Government Relations staffer Patricia Moody (center).

Legislators mingle with consortium participants at the Capitol Hill reception. Rep. Patrick Kennedy (D-R.I.) is seen with APA member Timothy Mueller, M.D., and Dorothy Sayer of the National Alliance for the Mentally Ill.

Rep. Timothy Murphy (R-Pa.) talks with consortium co-chair David Kupfer, M.D. (right).

Judd presents Rep. Rosa DeLauro (D-Conn.) with a plaque honoring her strong support of federal investment in biomedical and behavioral research.

Judd presents Kennedy with a plaque honoring his leadership on mental health issues and his support of the campaign to double the budget of the National Institutes of Health over five years.

Judd recognizes Rep. Bob Filner (D-Calif.) for championing the causes of veterans with mental illnesses and substance abuse disorders.

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Drug Abuse Prevention Agency Gets New Director

Drug prevention and treatment veteran Beverly Watts Davis will head CSAP's drive to replicate effective drug abuse prevention programs across the country.

BY JIM ROSACK

Substance Abuse and Mental Health Services Administration (SAMHSA) Administrator Charles Curie announced in April that Beverly Watts Davis will take the helm of the Center for Substance Abuse Prevention (CSAP) early this summer.

CSAP, one of SAMHSA's three centers, works in partnership with federal agencies, state and local governments, and public and private sector organizations to prevent the onset of illegal drug use, alcohol abuse, and tobacco use by fostering resilience among youth and promoting protective factors within communities.

Watts Davis has worked in the substance abuse field since 1988. She is currently the senior executive vice president of United Way in San Antonio, Tex., and executive director of the San Antonio Fighting Back Anti-Drug Community Coalition.

Watts Davis has an extensive background in managing multisite community grant programs and comprehensive prevention and early intervention treatment programs for children and adolescents, ethnic minorities, pregnant and postpartum women, and ex-prisoners reentering society.

Curie praised her "proven leadership and extensive experience in community mobilization," calling it pivotal as the center moves to design and implement a strategic framework for prevention at the community level throughout the nation.

More information on CSAP is posted on its Web site at <www.samhsa.gov/centers/csap/csap.html>. ■

Bill Would End Medicare's Discriminatory MH Copayment

Recently proposed legislation would eliminate the Medicare 50 percent copayment imposed on beneficiaries who use outpatient psychiatric services.

BY CHRISTINE LEHMANN

The elderly would pay a 20 percent copayment rather than the current 50 percent copayment for outpatient psychiatric visits under the new Medicare Mental Health Copayment Equity Act of 2003 (S 853).

APA president Paul Appelbaum, M.D., praised the bill, which was introduced by Sens. Olympia Snowe (R-Maine) and John Kerry (D-Mass.) last month. The bill was referred to the Senate Finance Committee.

"This legislation helps fulfill APA's historic efforts to end Medicare's discriminatory outpatient coverage of treatment for mental illness," said Appelbaum in a statement released by APA. "It gets us to where we need to go in a way that is fully responsive to the needs of Medicare beneficiaries while being fiscally responsible, given Medicare's budget picture."

Moreover, he added, "It's a creative approach to problem solving that amply warrants our thanks and strong support."

The Medicare Mental Health Copayment Equity Act of 2003 would amend title XVIII of the Social Security Act and reduce the 50 percent copayment for mental health services to 20 percent over six years.

Mental illness is a major health problem for the nation's elderly. According to a report by the U.S. surgeon general, up to 20 percent of older adults and nearly 40 percent of older adults in primary care settings in this country experience symptoms of depression, according to the statement.

The elderly also have the highest suicide rate in the nation, and the risk of suicide increases with age (see story on page 9).

"The current Medicare system imposes a policy of discrimination by diagnosis that inflicts a heavy toll on Medicare patients, who, by no fault of their own, happen to suffer from mental illness. This is a shameful policy to have written into federal law," said Appelbaum.

He continued, "This legislation would end this statutory discrimination by requiring that Medicare patients pay only the same 20 percent copayment for mental illness treatment that they pay when they seek any other medical treatment, including, for example, treatment for diabetes, cancer, heart disease, or the common cold."

He commended Snowe and Kerry for their "tireless dedication to ending discrimination against persons struggling with mental illness. We pledge to work with them and all members of Congress to see that this landmark bill becomes our national law," said Appelbaum.

The Medicare Mental Health Copayment Equity Act can be accessed on the Web at <http://thomas.loc.gov> by searching on the bill number S 853. ■

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Bill Could Threaten State Parity Mandates

The Bush administration is promoting a controversial strategy to address the problem of the uninsured.

BY KATE MULLIGAN

APA and other mental health advocacy organizations are fighting proposed legislation that threatens state parity laws and other consumer protections.

On April 8 the House Education and Workforce Employer and Employee Subcommittee voted to approve the Small Business Health Fairness Act of 2003 (HR 660) by a vote of 13 to 8.

The bill, which is intended to address the problem of the growing number of Americans without health insurance, would allow businesses in the same trade groups to form association health plans (AHPs).

Those plans would be exempt, however, from state laws that mandate parity and provide consumer protections.

In fact, in September 2002 the Department of Labor released a report that praised AHPs because "by operating under federal law, [they] can avoid the cost of state benefit mandates."

The report, "Association Health Plans: Improving Access to Affordable Quality Health Care for Small Businesses," lists as an "AHP advantage" the fact that other insurance offerings are hampered by the "high cost of having to comply with the requirements of up to 50 state insurance companies, including state-mandated benefit requirements."

At that time, Labor Secretary Elaine L. Chao called on Congress to pass the AHP legislation. In a written statement, she said, "Association health plans would equalize the playing field for small businesses, but, more importantly, would result in health insurance coverage for millions of uninsured workers and their families" *(Psychiatric News*, November 1, 2002).

The report listed 32 organizations that support the legislation. Among them are the National Association of Manufacturers, U.S. Chamber of Commerce, and National Federation of Independent Businesses.

On January 16 APA joined other members of the Mental Health Liaison Group in a letter to Rep. Dennis Hastert (R-Ill.), speaker of the House, and Sen. William Frist, M.D., (R-Tenn.), Senate majority leader, opposing legislation that "would exempt association health plans from state regulation and thereby undermine state mental health parity laws and other critical consumer protections."

The signatories argued that "AHPs would reduce costs by offering pared-down benefit packages excluding coverage of mental health services or prescription drugs, for example. These low-cost plans would appeal to those firms with primarily young, healthy employees, but as a result those in need of more comprehensive benefits would have to pay more for traditional coverage."

Subcommittee Democrats introduced amendments to the legislation that would have required AHPs to adhere to state laws that require health plans to provide certain benefits, such as laws that require coverage for diabetes and substance abuse, and also to adhere to state laws concerning prompt payment of claims and external review of coverage decisions.

The subcommittee defeated the amendments.

Nicholas Meyers, deputy director of APA's Division of Government Relations, said, "APA remains deeply concerned about the potential for AHP legislation to wall off underlying state coverage requirements and undermine successful state efforts to end discriminatory coverage of mental illness treatment. We're trying to ensure that state gains are not sacrificed in the understandable desire in Congress to expand options for coverage of the uninsured. It's not an easy sell right now." ■

Depression

continued from page 8

do anything. I felt like I was sleepwalking through my day."

Colton continued, "I realized something had to change. So, one evening, I decided I wanted to end it and attempted suicide. I was hospitalized and released that night when I promised the staff I would get help the next day."

It took a while because his student health insurance did not cover care from psychiatrists, and primary care physicians in his plan were concerned that he was a liability risk and refused to treat him, said Colton. He finally received affordable help at a public mental health clinic.

"The reason I am doing this campaign is to urge others to take the initiative and not to wait until it captures you like it did me," he said.

Carmona added, "Today, we are saying to men it's all right to talk to someone about your thoughts and feelings or say that you're hurting. Real men also need to be role models for their children. I have two sons, and they look to me not only for words but actions. When men step forward and get help for depression, they are making it easier for the next generation of men to not have to suffer in silence."

Information about the NIMH Real Men, Real Depression campaign is available on the Web at <www.nimh.nih.gov> or by phone at (866) 227-6464. ■

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State's MH Inspector General: Watchdog, Detective, Psychiatrist

A Virginia psychiatrist is holding a position that appears to be unique: She is inspector general of her state's public mental health system. She hopes that some other states might create a similar position.

BY JOAN AREHART-TREICHEL

The Commonwealth Center for Children and Adolescents in Stauton, Va., is one of the facilities Everett and her staff inspect. So is Western State Hospital, which is next door.

It is an indigo-blue-sky day in Charlottesville, Va. The sun-dappled magnolia leaves rustle softly in the breeze. A blond, 42-year-old woman in a charcoal turtleneck pullover and slacks opens the front door of her home and welcomes a visitor in for a chat.

Anita Everett, M.D.: "What we do is make unannounced inspections to make sure that patients are safe and receiving appropriate treatment."

The woman is psychiatrist Anita Everett, M.D., whom Virginia colleagues describe as "warm, caring, organized, and energetic"; "very smart, knows a lot of medicine, knows a lot of psychiatry, highly respected, and much liked, all in all a very solid person."

And if that is not enough, Everett holds a position that appears to be unique—inspector general of her state's public mental health system.

True, there are other inspector generals around the United States, but none of those positions are comparable to that in Virginia, and none is occupied by a psychiatrist. For instance, Everett explains, Illinois has an inspector general for human services, but that person handles mostly abuse and negligence cases and is not a psychiatrist. Florida has an inspector general for its system that falls under child and family services, but the inspector general's role has more to do with financial auditing. There was some form of inspector general in the District of Columbia who reported on problems in the living quarters of persons with mental retardation, but the person filling that position was not a psychiatrist.

Crisis Prompted Position

The reason that the position of inspector general of Virginia's public mental health system was created, Everett said, started back in the mid-1990s when "we had a person die while in seclusion and restraint at one of our hospitals." The U.S. Department of Justice then investigated the public mental health facilities of Virginia and found a number of them woefully lacking in terms of safety and treatment.

Then in 1997, the attorney general of Virginia, James Gilmore, ran for governor and promised that if elected, he would set up a position to serve as a watchdog over Virginia's public mental health system. He was elected as governor and kept his word: In 1999 the Virginia legislature passed a bill that created the position, and he signed it into law. He then appointed Everett to the position since she had had extensive experience in public mental health—having been medical director of a rural mental health clinic near Staunton, Va., from 1992 to 1999.

Everett has a very small staff—only two people—though she can occassionally hire consultants. "We are focused primarily on Virginia's 15 state mental health facilities, which care for some 3,600 patients," Everett explains. "But we also have the authority to review the quality of clinical services in community mental health programs licensed by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, which are in the hundreds.

"What we do is make unannounced inspections to make sure that patients are safe and receiving appropriate treatment. This includes not just talking with staff, such as aides and night nurses, but with patients themselves."

Four Years, 700 Recommendations

During the four years that she has been inspector general, Everett and her staff have sent 78 reports containing some 700 recommendations to the governor. "Some of our recommendations are very small things," she says, "like replacing shredded curtains, and some of our recommendations are quite big—like hiring more nurses so that they don't have to work overtime and become exhausted and then perhaps neglect or abuse patients."

The Virginia Department of Mental Health is required by the Code of Virginia to respond with a corrective action plan to each recommendation made by Everett and her staff. If the department is not able to implement the recommendation, it is required to justify its decision in a plan of correction that is released on the Web site of the Office of the Inspector General.

Examples of the kinds of recommendations that have been implemented in one or more facilities include the hiring of new nurses, increasing access to primary care physicians, replacing antiquated equipment that caused injuries, and resolving a fire code violation that placed adolescents at risk.

Still other things that she and her staff have achieved, Everett says, are examining patient discharge plans from state facilities to see whether the plans are appropriate to patients' reintegration into the community; scrutinizing the causes of deaths in state facilities to make sure that patients did not die because of lack of safety or because of inadequate treatment; and probing the ability of seriously, persistently mentally ill patients to access services in community mental health centers.

Playing Watchdog Not Easy

Nonetheless, playing detective—watchdog if you will—is not always easy, Everett concedes. "I think the biggest challenge is being a physician who sometimes has to question the practice of other professionals. Sometimes the staff members I inspect feel threatened by me, but they really shouldn't. My interest is the same as theirs, to provide the best patient care possible."

Another difficulty, she adds, "is ques-

please see ***Everett*** *on page 56*

Colleagues Reflect on Va. Psychiatrist's Tenure as MH Inspector General

Virginia psychiatrists propose a variety of objectives that they'd like to see Anita Everett, M.D., accomplish in her time left in the position as inspector general of her state's public mental health system.

BY JOAN AREHART-TREICHEL

Not surprisingly, Virginia psychiatrists are quite pleased that government officials have created an office of inspector general for Virginia's public mental health system. "I think it is good to have somebody in the field of medicine and psychiatry, someone like Dr. Anita Everett, who can look objectively at very emotional issues and recommend good system fixes," Jorge Cortina, M.D., a geriatric psychiatrist with the Veterans Affairs Medical Center in Hampton, Va., told *Psychiatric News*.

"It was certainly a good idea that such a position was created," J. Gregory Fisher, M.D., a Lynchburg, Va., psychiatrist and president-elect of the Psychiatric Society of Virginia, said in an interview, "because unfortunately Virginia's state mental hospitals, like those in a lot of states, have had a checkered history. I think the state has worked hard to improve the mental health system and get above board, but I think the position of inspector general has helped with that process significantly."

Virginia psychiatrists are quite pleased with Everett's performance as inspector general. "She has done an excellent job," opined Charles Davis, M.D., medical director of Central State Hospital in Petersburg, Va., which is one of the public mental health facilities under Everett's purview. "It is a demanding and difficult role. The state hospitals are where the most troubled individuals go. And many times they are prone to behaviors that may be injurious to themselves or others, which are difficult for the public to understand. . . ."

"She fills a vital function in terms of people knowing that their system is being looked at by someone who insists that a good job must be done, but who is also on their side," asserted John Shemo, M.D., a Charlottesville, Va., psychiatrist and a district branch representative to the APA Assembly. "She doesn't have any agenda other than having the system work better. . . ."

"Although I do not work in the state mental health system, I do know that I am reading less about our state mental hospitals in the newspapers than I was several years ago," Fisher said. "That indicates that Dr. Everett has made a positive difference."

Virginia psychiatrists have a list of objectives that they would like Everett to achieve in the time that she has left as inspector general.

"I would like to see more coordination or tightening of relations between the public and private mental health sectors," Fisher said. "I'm not sure how she could achieve that in her position. However, there is currently a lack of working together between the two sectors, and anything that could be done on either side to ameliorate the situation would be of value."

"I hope that she'll be able to influence the dumping of patients out of the state mental hospitals," Shemo asserted. "There are a lot of patients in our state, as in every state, who either end up in the prison system or in poorly funded domiciles where there is no real care or protection. I know that Anita feels strongly about these issues. In the APA Assembly, she was able to help get a block of five action papers passed, all of which specifically addressed the needs of the severely and persistently mentally ill."

"I think that the people with power in our state—the governor, legislature, department of mental health—are pleased with her work," David Markowitz, M.D., a Richmond, Va., psychiatrist and president of the Psychiatric Society of Virginia, opined. "So I don't think there is anyone who would like to see the position of inspector general go. But at the same time, everybody protects their own piece of the pocketbook. So I wish that she could find some way to transition her position into a permanent one to help the public mental health system." ■

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Women M.D.s See Progress, But Goals Still Elusive

Although there are many more women physicians today than in years past, inequality and discrimination continue to hamper their professional progress, according to the president of the American Medical Women's Association.

BY EVE BENDER

An APA fellow is dedicating the next year to promoting equity for women in medicine as president of the American Medical Women's Association (AMWA).

Lynn Epstein, M.D., clinical professor emerita of psychiatry and community health at Brown University in Providence, R.I., became president of AMWA in late January. Epstein is most recently professor and dean of health sciences at the Massachusetts College of Pharmacy and Health Sciences, which is located in Boston and Worcester, Mass.

AMWA, founded in 1915, is an organization of 10,000 women physicians and medical students working to advance the place of women in medicine and improve women's health.

Epstein told *Psychiatric News*, "If there is a theme to what I wish to accomplish as president, it is one of collaboration."

Whether it is collaboration between men and women physicians or between AMWA and different medical specialty organizations such as APA, Epstein said, each of the collaborators benefits, as well as the patients they serve.

Lynn Epstein, M.D.: "We have made a great deal of progress, but we have not yet achieved our goals—there is not yet equity for women in medicine."

Epstein earned her M.D. at Johns Hopkins University School of Medicine in Baltimore and completed her psychiatry training there as well. "In medical school," Epstein said, "I had a chance to put my passion for people into a scientific perspective—I would say I was a psychiatrist long before I became one professionally."

Epstein said that while in residency training at Johns Hopkins in the early 1970s, barely 10 percent of her colleagues were women. "It was a totally different environment" than that of today's psychiatry residency training programs, where women represent almost half of all residents, she said.

Today, of the nation's 813,770 physicians, 195,537 are women, according to the AMA's 2002-2003 edition of *Physician Characteristics and Distribution in the U.S.*

Focusing on women's issues at the time was, Epstein said, "a luxury one could ill afford" and that the way to advance the role of women in medicine was for residents like her to "do an excellent job and show their commitment" to a career in medicine.

She went on to become an assistant professor at the Johns Hopkins University

"If there is a theme to what I wish to accomplish as president, it is one of collaboration."

Counseling and Psychiatric Service until the mid-1980s, when she assumed a position as consultant to the dean of medicine at Brown University, and later, associate dean of medicine both for student development and women's affairs.

While consultant to the dean of medicine, Epstein recalled, women faculty brought their concerns to her about "equity on the job."

For instance, Epstein heard complaints from full-time women medical faculty who were asked to go part time because they were pregnant. "I didn't feel like I could just listen," Epstein said. "If I listened, I needed to take some responsibility."

Epstein helped to establish the Office of Women in Medicine at Brown University in 1991. "I rallied staff support for activities in which women medical faculty participated," she said. Some of the activities were mentoring, leadership training, and faculty development training, for instance.

She has also been actively involved with the Association of Women Psychiatrists since 1989 and served as president of the association from 1995 to 1997. There, Epstein worked with other AWP leaders to establish the association's Leah Dickstein Award, which is presented to a woman medical student annually.

As president of AMWA, Epstein said, she will focus her energies on aiding the organization with its central missions—educating the public about women's health issues, advocating for quality health care for women patients, and creating support for women leadership in the field of medicine.

Equity for women patients, Epstein said, means "having symptoms and illnesses taken

please see ***Women*** *on facing page*

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Frustration Gives Birth to Web Site

BY DAVID LEICKEN, M.D.

The early-career period is often a very challenging time in the life of a psychiatrist. In addition to getting established in a new job, paying back loans, and adjusting to the weight of new levels of responsibility, there are the stresses of the ever-looming board exam.

As it turned out, I was one of the many whose board exam results come back with a "negative determination." Failing Part II of the boards affected me in a profound way. As I struggled for several months to re-establish my equilibrium and put the experience into context, I took inventory of the process.

Other than the "Boarding Time" guide to the ABPN exam, I could find little information about the psychiatry boards, including how to prepare for and conduct myself during the patient exam part of the boards.

Part I seemed straightforward enough. If one were to fail, it was probably due to either inadequate textbook study or test-taking anxiety.

Part II, in contrast, is completely different. You are being judged by your peers and more-senior colleagues, which is arguably a more subjective process than a written test. You know nothing about the patient you are expected to interview. You get no immediate feedback from the examiners. You travel hundreds of miles, dressed in clothes you would sooner wear to a wedding than to work. You are asked to interview a stranger in front of other strangers in a strange city. The whole experience was foreign to me, and I found myself ill prepared.

Even after passing Part II, however, I was left with mixed feelings. While relieved, I still felt frustrated by the process. Much of the information I gathered about how best to prepare for Part II came from friends' "war stories" about what worked or did not work for them. Beyond those stories, it took a tremendous amount of detective work, self-analysis, and repetitive practice to find the balanced approach needed to pass.

Having had this much trouble preparing, I concluded that there must be many others in the same situation who could use some help. Out of this frustration, I decided to act.

One night in March last year, I began looking up domain names on the Internet. Somewhat impulsively, I decided to register the name "Psychboards.org" and set up a server account, not knowing exactly what I would do with it. Over the following few days, I began to brainstorm. I tried to remember what information I had wanted when preparing for the boards a few years earlier, and that became the genesis of the Web site.

The first page to be developed provided basic information about test dates, with added links to the corresponding hotels and cities. Next came the message board and a resource list to help guide those preparing for the test. Some entertaining items were also added, such as psychiatric hangman and the "psychobabble generator."

I designed the site's structure to be interactive, with the goal of developing a community where people could come to exchange information and find support.

Since March 2002, the Web site, <www.psychboards.org>, has experienced steady growth, with more than 7,000 visitors as of mid-April. A number of people have offered some useful suggestions that may be included in future revisions. So far, this has been an exciting endeavor, which I believe will grow in quality and usefulness as more people visit and participate. ■

Dr. Leicken is associate chief of staff for mental health at the Carl T. Hayden VA Medical Center in Phoenix. He is also president-elect of the Arizona Psychiatric Society. He can be contacted by e-mail at admin@psychboards.org.

Women

continued from facing page

seriously by health care professionals and having access to evidence-based data and state-of-the-art treatment for illnesses that affect women."

There is still much work to be done in the area of women's issues, Epstein emphasized. "We have made a great deal of progress, but we have not yet achieved our goals—there is not yet equity for women in medicine."

Many people may be lulled into a false sense of complacency, Epstein said, by believing that just because women are represented in medicine in greater numbers that they have the same opportunities men physicians do. "They don't," she said.

In addition, Epstein said, some women physicians are still dealing with harassment on the job, and the involvement of the entire community is necessary to end such behaviors. "When we have a community of men and women of good conscience," she said, "those behaviors will no longer be tolerated."

More information about AMWA is posted on the organization's Web site at <www.amwa-doc.org/>. ■

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professional news

Psychiatrists Make Sure Community Hears Youth-Violence Message

To combat youth violence in Puerto Rico, psychiatry faculty and residents went into the community to listen to the stories of those who live with violence every day and to offer them much-needed help.

BY EVE BENDER

Sharing the university's expertise with the local community, psychiatry residents and faculty at the University of Puerto Rico in San Juan have been able to teach the parents of violent and troubled youth to recognize the early warning signs of mental illness and find appropriate mental health services.

The psychiatric professionals were part of a communitywide effort to stem a flood of youth violence in recent years—which accounted for the majority of adolescent deaths on the island in 1999.

"Due to the impact that violence has in terms of emotional cost to victims and their families, as well as the health and safety of citizens," said Luz Colón de Marti, M.D., associate professor of psychiatry and residency training director at the University of Puerto Rico, "we decided we needed to address prevention and early intervention in violent behavior."

The residents and faculty have reached more than 1,000 parents, teachers, and other school staff through workshops all over the island on the prevention of youth violence, according to Colón de Marti, who spoke about the project at the annual meeting of the American Association of Psychiatric Residency Training Directors in March.

Working together to stop youth violence are (from left) Wanda Santos, APNI project coordinator; Luz Colón de Marti, M.D., associate professor and residency training director at the University of Puerto Rico; Gloria Suau, M.D., resident; Iris Rodriguez, M.D., resident; and Leslis Nazario, M.D., residency training director for the child and adolescent psychiatry program.

To reach the community, the university joined forces with the Violence Prevention Project at the Asociación de Padres Pro Beinestar de Ninos Impedidos Inc. (APNI) and the Association of Parents for the Welfare of Children With Disabilities.

APNI is a nonprofit organization founded in 1977 by a group of parents to improve educational services for children with disabilities.

The organization received a two-year grant in 2000 from the U.S. Department of Education to educate the community about violence and mental health issues. Colón de Marti said that when the grant is renewed, the university will continue its collaboration with APNI.

Learning About Violence

At the day-long workshops, anywhere from 30 to 150 parents and school staff gathered in various places in the community—police buildings, city halls, and health clinics, for instance.

In the mornings, according to Wanda Santos, APNI project coordinator, APNI staff and nonpsychiatric mental health professionals from the university equipped attendees with certain parenting skills, for instance. "We taught the parents how to relax and to control their anger so that they could better deal with their children" when the children were having problems, Santos said.

University psychiatry faculty then spoke to parents and school staff about risk factors for violent behavior, which can range from undiagnosed mental illness to poverty to unsupervised television or Internet use.

"We also taught attendees about how violence can be a problem in children with certain psychiatric disorders or organic medical conditions," said Leslis Nazario, M.D., the training director at the University of Puerto Rico's child psychiatry residency training program.

So that attendees became savvy to the possibility of mental illness in youngsters, faculty members taught them the warning signs associated with psychiatric illnesses such as attention-deficit/hyperactivity disorder, depression, substance abuse, and posttraumatic stress disorder.

But the majority of learning—and sharing—took place when psychiatry residents, under supervision by faculty, divided the workshops into smaller groups and discussed clinical vignettes with attendees.

Victim of Violence

The children at risk for violence in the sample vignettes were not unlike the children in the parents' and teachers' lives, the residents noted.

The group exercise—to identify some of the risk factors for violence in

please see ***Youth Violence*** *on page 54*

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Soaring Liability Premiums Force Practice Changes

An AMA survey finds that many physicians in "high-risk" specialties have ceased to provide certain services and are referring complex cases to other physicians.

BY MARK MORAN

Two-thirds of "high-risk" specialists have changed the way they practice medicine because of rising liability premiums and diminishing access to malpractice insurance.

In some cases, these changes have included ceasing to provide certain services and referring complex cases to other physicians, according to a survey of the nation's physicians by the AMA.

Here are some of the survey's findings:

• 64.8 percent of specialists in the high-risk specialties—emergency medicine, general surgery, neurosurgery, obstetrics/gynecology, orthopedic surgery, and thoracic surgery—have made changes in their practice, including no longer providing certain services, referring complex cases, and even closing their practice.

• 24.2 percent of high-risk specialists stopped providing certain services, including emergency and trauma care and delivering babies; 92.4 percent of the high-risk specialists who stopped providing at least some services said that liability pressures were important in their decision to stop providing certain services.

• 41.5 percent of high-risk specialists began referring complex cases. In "crisis" states—those states identified by the AMA in which premiums have risen most precipitously and access to insurance has dwindled—34 percent of physicians surveyed began referring complex cases, compared with 24 percent in non-crisis states. Crisis states include Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, New Jersey, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia.

The survey, begun in fall 2002, was a random sample of physicians in 20 specialty societies and 13 state medical societies. The survey was conducted online and asked about medical liability coverage and practice changes made in the two previous years. A total of 4,846 responses were received as of March 4.

Society-Wide Problem

Psychiatrists are not among the high-risk specialists, and though their premiums have risen somewhat, they remain at the low end of the spectrum. Alan Levenson, M.D., president and chief executive officer of the Psychiatrists' Purchasing Group, told *Psychiatric News* that he knew of no reports of psychiatrists substantially changing their practice or ceasing services because of liability concerns. The Psychiatrists' Purchasing Group sponsors the APA-endorsed Psychiatrists' Professional Liability Insurance Program.

But Levenson said the AMA survey data document a burgeoning problem that threatens all of medicine. "It is unfortunate to realize what kind of seriously negative impact the malpractice problems are having on physicians in other specialties," he said. "But in the long term, these kind of data are supportive of efforts for tort reform. It will take time for tort reform efforts to be successful and time for those steps to actually have the effect of bringing down malpractice premiums. Certainly, tort reform will be beneficial to psychiatry and all of medicine."

AMA President Yank Coble Jr., M.D., told *Psychiatric News* that the liability crisis is a "societal problem" affecting all physicians and all of their patients. "No one specialty can be immune," he said. "Even though psychiatrists are not immediately affected, their patients are affected."

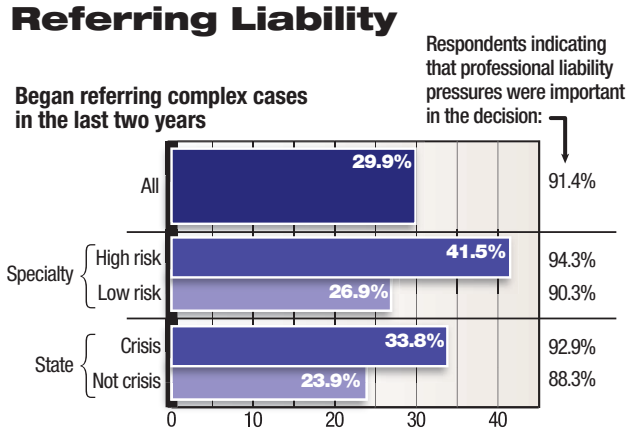
Coble said that some primary care physicians and radiologists were once considered low liability risks. Today, he said, some physicians have ceased providing mammograms, and in some regions of the country patients have to wait weeks or months for a mammogram.

Bill Would Ease Crisis

Coble said the Help Efficient, Accessible Low-Cost, Timely Healthcare Act of 2003 (HR 5), known in abbreviated form as the HEALTH Act—passed by the House of Representatives in March—would go a long way toward easing liability problems if it became law. That legislation limits pain and suffering damages, so-called "noneconomic damages," to $250,000. Punitive damages would be limited to two times the economic damages or $250,000, whichever is greater. The HEALTH Act also provides limitations on attorney's fees, to reduce attorneys' incentives to sue for unnecessarily large awards.

please see ***Liability*** *on page 53*

Referring Liability



Source: AMA, *National Physician Survey on Professional Medical Liability,* April 2003

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

Medicaid Pharmacy Problems Grow

BY IRVIN L. (SAM) MUSZYNSKI, J.D.

Psychiatrists must remain alert at the state level to the increasing use of pharmacy benefit management (PBM) techniques to control Medicaid costs. Fail-first policies, therapeutic substitutions, prior authorizations, and unknown appeals processes are being considered or already approved by state legislatures. To counteract this rising threat to clinical decision making, APA members can make the following points:

- Psychiatric drugs are different. Unlike other drugs, it can take from three to six weeks to determine a patient's response to a psychotropic.
- Patients have more idiosyncratic reactions to psychotropics than they do to other medications.
- Compliance is a far greater problem for patients taking psychotropics; switching patients from one drug to another can only exacerbate compliance problems.

Contact Karen Sanders of APA's Office of Healthcare Systems and Financing at (800) 343-4671 or Paula Johnson of the Division of Government Relations at (703) 907-8588.

Magellan Crisis

State insurance commissioners are responsible for facilitating the fair and equitable treatment of insurance consumers, so when Magellan filed for bankruptcy under Chapter 11 on March 11, APA had already written each commissioner about its concerns. APA President Paul S. Appelbaum, M.D., expressed concern about continuity of care for patients and reimbursement for clinicians/organizations. Twenty states have responded: Arizona, California, Florida, Georgia, Idaho, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Nevada, North Carolina, North Dakota, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, Washington, and Wisconsin.

The responses are summarized on the APA Web site at <www.psych.org>.

Managed Care Help Line

Members are calling about Magellan's bankruptcy, although there are no reports of delays in payments. APA members most often call about how to start a practice; Medicare fees; pharmacy benefit management problems; and medical record retention.

The Managed Care Help Line can be reached at (800) 343-4671.

Cuts in Medicare Fees Projected

Under the Medicare formula, physicians are subject to pay cuts anytime the numbers of physician services increase more rapidly than the gross domestic product. In a March 20 letter to the Medicare Payment Advisory Commission, the Centers for Medicare and Medicaid Services (CMS) projected another fee cut for physicians in 2004. Based on current data, CMS is reporting that the Physician Fee Schedule (PFS) update for 2004 will likely be between -5.8 percent and 0.6 percent with a point estimate of -4.2 percent. For psychiatrists, this means a fee reduction for the third straight year, despite recent legislation to correct the flaws inherent in the physician reimbursement formula. APA, in coordination with the AMA, will continue to work with CMS and Congress to address the continued decline in physician reimbursement.

See <www.psych.org> or call (800) 343-4671.

Choosing the Right CPT Code

Use the code that most accurately reflects the service provided. For the typical initial evaluation, use 90801 or the appropriate Evaluation and Management (E/M) code—the 99XXX series. If psychotherapy is the predominant service, choose the appropriate psychotherapy code. Use the psychotherapy code with E/M codes if the session includes five to seven minutes of medical management (review of medications, side effects, physician orders, interpretation of lab results). For medical management (with little or no psychotherapy), choose 90862 or the appropriate level E/M code. If counseling and coordination of care are the predominant services, use the appropriate E/M code.

Caution: When selecting an E/M code be sure to let the situation drive the level. The more complex the case, the more likely it will require a higher level of work. Most situations will result in the use of a level

please see ***Pharmacy*** *on page 59*

Psychiatric Practice & Managed Care (PP&MC) and *Psychiatric News* will continue updating APA members on practice management issues via the pages of *Psychiatric News.* This abbreviated version of PP&MC will be printed bimonthly in *Psychiatric News* and will coincide with each new issue of PP&MC posted online.

Go to www@psych.org; click on Newsletters.

Mr. Muszynski is director of APA's Office of Healthcare Systems and Financing.

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annual meeting

Issues Important to MITs Focus of Several Sessions

A number of annual meeting sessions and events planned specifically for psychiatry residents promise to make the meeting professionally and personally worthwhile.

BY NANCY DELANOCHE

APA's 2003 annual meeting may be the first major psychiatric meeting that many residents will attend. To make the experience as rewarding as possible, APA, through its Division of Education, Minority, and National Affairs, has planned a packed schedule of educational sessions and special events for residents only.

A place to hang out at the meeting and chat informally with other residents is one of the purposes of the new Resident Resource Center. The center will also be the site of a special residents-only series of discussions with distinguished psychiatrists—including incoming APA President Marcia Goin, M.D.—who are renowned in their fields of expertise (see box on facing page for schedule). No other session format in the APA annual meeting gives residents an opportunity to get up close and personal in a small-group setting with these experts.

The center, located in Pacific Conference Suite I on the fourth floor of the Marriott, will be open from Sunday, May 18, through Tuesday, May 21, from 7 a.m. to 6:30 p.m.

An event on Sunday, May 18—"The Second Annual Global Psychiatry Luncheon"—combines education with an opportunity to meet residents and faculty from Sweden over lunch. It will be held at noon in room 132 on the exhibit level of the Moscone Center.

The event includes an educational session on the theme "Patients Who Do Not Easily Fit Into Diagnostic Categories" in which case presentations will be made about patients who made suicide attempts or requested to die. Panelists include Robert Spitzer, M.D., Philip R. Muskin, M.D., and Dr. Jörgen Herlofsson. Spitzer is an international authority on psychiatric diagnosis; Muskin is a consultation-liaison psychiatrist and past chair of APA's Scientific Program Committee; Herlofsson is a renowned psychiatric diagnostician who has translated *DSM-IV* into Swedish.

Residents Summit

Each year the "Residents Summit" provides an opportunity for residents to come together and discuss an issue of importance to them. This year's topic is "An Ethical Framework for Physician Interactions With the Pharmaceutical Industry." It will be held Monday, May 19, at 3:30 p.m. to 5 p.m. in Parc Ballroom II on the fourth floor of the Renaissance Parc 55.

As many residents have probably discovered by now, physician contact with the pharmaceutical industry is frequent during and after residency training. Michael Jibson, M.D., director of psychiatry residency training at the University of Michigan in Ann Arbor, has created a curriculum to help residents construct an ethical framework in which to evaluate these interactions. The goal of the session is for residents to develop informed, clear, and thoughtful standards for these interactions. Participants will also have an opportunity to discuss their experiences and ask questions.

The summit will be followed by a reception for residents sponsored by the department of psychiatry at the University of California-Davis.

Early Research Career Breakfast

The Early Research Career Breakfast, sponsored by the American Psychiatric Institute for Research and Education, presents an opportunity for medical students and residents interested in psychiatric research careers to join with psychiatric research fellows and junior research faculty to talk informally with distinguished senior researchers. Tables are set up by area of research interest, and attendees are encouraged to circulate freely.

The breakfast will be held Tuesday, May 20, at 7 a.m. in Barcelona II on the third floor of the Renaissance Parc 55 Hotel. Since this is an invitation-only event, those who are interested in attending are asked to send an e-mail message to edalder@psych.org. ■

Ms. Delanoche is program manager in APA's Division of Education, Minority, and National Affairs.

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Annual Meeting Events for Psychiatry Residents, Fellows

APA has planned a full schedule of events for psychiatry residents and fellows so they can meet and socialize with one another, ask questions and share information, meet psychiatric experts, and learn more about their chosen profession. More information is available by contacting Nancy Delanoche by phone at (703) 907-8635 or by e-mail at ndelanoche@psych.org.

Sunday-Tuesday, May 18-20

Resident Resource Center, Pacific Conference Suite I, fourth floor, Marriott

Residents now have a place to relax and meet colleagues at the annual meeting. There will be specialized programming in the center each day (see below). Medical students are also encouraged to stop by for information on residency training programs.

Residents-Only Discussion Series in Resident Resource Center (11 a.m.-12:30 p.m.)

Monday, May 19	"Disasters During Training: Dealing With Personal and Patients' Crises," Marcia Goin, M.D.
Tuesday, May 20	"Maintaining/Developing Family Relationships During Residency," Glen Gabbard, M.D.
Wednesday, May 21	"Cross-Cultural Issues: When the Patient Is Different From You," Carl Bell, M.D.

Sunday, May 18

9 a.m.-10:30 a.m.	"How to Survive the Annual Meeting" (for medical students and residents) *Pacific Conference Suite I, fourth floor, Marriott*
Noon-2 p.m.	Luncheon for U.S. international residents *Room 132, exhibit level, Moscone Center*

Monday, May 19

7 a.m.-8:30 a.m.	"Meet the Experts: Sunny-Side Up" Breakfast *Golden Gate Hall C, B-2, Marriott*
3:30 p.m.-5 p.m.	Residents Summit: "An Ethical Framework for Physician Interactions With the Pharmaceutical Industry" (see article on page 28) *Parc Ballroom II, Renaissance Parc 55*
5 p.m.-6 p.m.	Reception for residents sponsored by UC-Davis department of psychiatry *Parc Ballroom III, fourth floor, Renaissance Parc 55*

Tuesday, May 20

Noon-2:30 p.m.	Luncheon for residents, medical students, and educators *Monterey I, third floor, Nikko Hotel*

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Assembly Caucuses to Meet During Annual Meeting

Monday, May 19

5 p.m.-6 p.m. **Caucus of International Medical Graduates**
Room 264, mezzanine level, Moscone Center

Tuesday, May 20

5:30 p.m.-6:30 p.m. **Caucus of Hispanic Psychiatrists**
Union Square 10, fourth floor, Hilton
Caucus of Black Psychiatrists
Room 110, exhibit level, Moscone Center

5:30 p.m.-7 p.m. **Caucus of Lesbian and Gay Psychiatrists**
California East, second floor, Westin St. Francis

6:30 p.m.-7:30 p.m. **Caucus of Asian-American Psychiatrists**
Dante, fourth floor, Renaissance Parc 55

Wednesday, May 21

7 a.m.-8:15 a.m. **Caucus of American Indian, Alaska Native, and Native Hawaiian Psychiatrists**
Miland, third floor, Renaissance Parc 55

New Asian Art Museum Debuts in San Francisco

Art lovers who want to be immersed in art from non-Western traditions should make a point of visiting San Francisco's renowned Asian Art Museum, which just opened in its new home.

One of the leading lights of San Francisco's cultural scene is ready to show off its brand-new home. On March 20 the Asian Art Museum cut the ribbon on its new quarters in the city's old Main Library in the Civic Center area that also houses the opera house and city hall. For 35 years the museum was located in Golden Gate Park, but its collection had long ago outgrown that facility.

The challenge of turning the 1917 Beaux Arts library into a showcase for the museum's collection of more than 14,000 Asian art objects was bestowed on architect Gae

The Chinese Buddhist Arts gallery is just one of many exhibits at San Francisco's new Asian Art Museum.

Aulenti whose reputation soared with his dramatic transformation of Paris's rundown Gare D'Orsay train station into the widely praised Musée D'Orsay, which houses France's treasure trove of Impressionist and Postimpressionist art.

It took a $160.5 million fundraising campaign to see the project to completion, with $15 million, the largest single gift, coming from Chong-Moon Lee, a Silicon Valley high-tech entrepreneur. In return for that gift, the museum's official name will be the Asian Art Museum–Chong-Moon Lee Center for Asian Art and Culture.

The new museum's design preserves the architecturally distinct exterior of the old library and most of the dramatic interior details such as its vaulted ceilings, grand staircase, and skylights.

Visitors enter a first floor that contains exhibition galleries, educational facilities, museum store, and restaurant with outdoor café. The second and third floors, will show off several thousand works from the museum's collections, which span 6,000 years of history. Among the musuem's treasures is the world's oldest known Chinese Buddha, dating from 338.

For the last decade the museum has been committed to increasing its collections of contemporary art, and many of those additions will be on display. The goal of this expansion "is to contribute to an international dialogue about art in our own age and to an understanding of what defines or distinguishes the art being produced by Asians and Asian Americans."

A special exhibit that will be on display during the APA annual meeting in May explains the ideas and process that went into the design of the new facility.

Another exhibit is "From Monastery to Marketplace: Books and Manuscripts of

please see ***Museum*** *on facing page*

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Chinatown: Far More Than a Tourist Attraction

Chinatown may be second only to Fisherman's Wharf as a destination for tourists, but it still is home to many Asians.

BY KATE MULLIGAN

SFCVB photo by Kerrick James

A 1969 gift from the Republic of China, the dragon-crested gate at Grant Avenue and Bush Street is the front door to San Francisco's colorful, clangorous Chinatown.

How many Chinatowns are there in the San Francisco area? San Francisco writer Randolph Delehanty argues that there are four: the old Chinese neighborhood of 20,000 residents, a cultural mecca for the Bay Area's assimilated Chinese Americans, a special shopping district for non-Chinese San Franciscans, and a famed tourist attraction.

Whatever the number, the area offers endless possibilities for exploration. Chinatown Gate, at the junction of Bush Street and Grant Avenue, leads to the area's primary tourist thoroughfare.

Just one block to the west of Grant Avenue, however, lies Stockton Street, a more interesting destination for visitors who want to experience the Chinatown known to its residents.

Grocery stores, pastry shops, fishmongers, meat markets, and herbal shops line the street. Sidewalks are packed with Chinatown's residents going about their shopping.

The headquarters of the Chinese Consolidated Benevolent Association (or Six Companies) is at 843 Stockton. This brightly colored building was the site of a great deal of historic drama, according to Delehanty. In 1882 the U.S. Congress passed the Chinese Exclusion Act, which prohibited Chinese laborers from entering the country for 10 years. It was the culmination of a series of anti-Chinese legislative actions and remained in effect until 1943.

Chinatown's "mutually suspicious key associations" banded together in the face of the external threat to their well-being, and the organization became a "cockpit for personal and group political, economic, and social contention."

Today, Waverly Place (actually, an alley) is home to many of the area's benevolent associations. From Stockton, go east at Clay Street to Waverly.

Portsmouth Square is at right angles to Clay and Kearney streets. This was the center of activity in the mid-1850s, when people rushed to the area as the result of the discovery of gold.

In fact, the famed Chinese laundry can trace its origins in the United States to the Gold Rush. Chinese immigrants established laundries and other businesses to serve the miners.

The Chinese Culture Center is near the square, at 750 Kearney Street.

The earthquake of 1906 also helped to shape the history of Chinatown. Buildings were leveled and later replaced by Edwardian architecture embellished with theatrical chinoiserie. The pagoda-capped buildings at California and Grant are typical of this period, as is the Pacific Telephone Exchange building located at the corner of those two streets.

For tea to go, try the Imperial Tea Court (1411 Powell Street). The shop has rows and rows of various dried tea leaves, which you can sample. The Wok Shop (781 Grant Avenue) features what you might expect, and the Great China Art Company (857 Washington Street) offers vases, china, and knickknacks for sale.

"Going out for Chinese" is not a simple matter in Chinatown. Almost everyone is familiar with Cantonese-style cooking, and many diners have learned that Hunan and Szechuan restaurants are known for the use of red chili peppers. But you might want to try food labeled Hakka (an ethnic group that populates southern China) for the less frequently encountered dishes of salt-baked chicken or fish-stuffed bean curd.

Shanghainese food features seafood and waterfowl, and Taiwanese restaurants are known for stews, soups, and poopia, a thin pancake used to wrap finely shredded meat and vegetables.

And, then there's dim sum, which requires a vocabulary all its own. It can include such items as steamed octopus ball, chicken feet with black bean sauce, and shredded chicken fun roll.

Here are suggestions from online San Francisco guides:

Jai Yun (923 Pacific Avenue) on the border of Russian Hill and Chinatown, offers no menu, but has recently become the "hottest restaurant in Chinatown." Oriental Pearl (760 Clay Street) provides "a warm welcome, fair prices, fresh dim sum, and a bit of serenity."

Sam Lok Restaurant (655 Jackson Street) features Szechuan cooking. Preserved vegetables appetizer, sweet potato pancake, and braised fish dishes are recommended.

Lines form about an hour before opening for the House of Nanking (919 Kearny Street). Recommended dishes are tofu peanut sauce, chicken in beer sauce, and shrimp.

Dina Gan and Jeff Yang offer chopstick etiquette. Never stick your chopsticks upright in your rice bowl, they caution, because upright sticks look like the incense sticks used to honor the dead.

And, for the real novices, they include this bit of advice: use a spoon for soup.

More information on Chinatown's history and leading restaurants can be found on the Web at <www.sanfranciscochinatown.com/>, <www.sfgate.com/traveler/guide/sf/neighborhoods/chinatown.shtml>, <www.tools.ktvu.com/restaurants/food/reviews/top picks—chinatown.html>. ■

Museum

continued from facing page

Asia," which plays on the theme of the museum's new home being a former library. It presents, according to the museum's Web site, "45 examples of secular and religious texts, albums, calligraphy, and manuscripts that highlight the significance of illustrated and written materials in many Asian cultures."

Visitors who make it back to San Francisco from June through September will be able to experience an exhibit of more than 200 Indonesian rod puppets depicting mythical kings and queens, gods and monsters, and heroes and heroines from Indonesian history and folklore, most based on Hindu and Islamic texts and presented as theater.

The Asian Art Museum is at 200 Larkin St., and is open every day but Monday. Admission is $10 for adults, $7 for seniors, $6 for youth aged 12 to 17, and free for those under age 12. The museum's Web site is <www.asianart.org>. ■

Activities of Interest To International Medical Graduates

Sunday-Tuesday, May 18-21
IMG Resource Center
Sunday-Monday, May 18-19, 8 a.m-6 p.m., SOMA 1, second floor, Courtyard by Marriott
Tuesday-Wednesday, May 20-21, 8 a.m-6 p.m., room 224, mezzanine, Moscone Center

IMG Resource Center Sessions for IMGs

Tuesday, May 20	12:30 p.m.-1:30 p.m., "Talking About the Boards" with Rodrigo A. Muñoz, M.D.
Wednesday, May 21	Noon-1:30 p.m., "Making a Living: Psychiatrists' Income Today" with Steven Sharfstein, M.D. This session covers financial survival skills for psychiatrists in today's medical marketplace.

Other Sessions of Interest to IMGs

Monday, May 19

5 p.m.-6 p.m.	Caucus of International Medical Graduates *Room 264, mezzanine level, Moscone Center*

Tuesday, May 20

9 a.m.-10:30 a.m.	Component workshop: "Challenges and Solutions" *Salons 12 and 13, lower B-2 level, Marriott* Discussion group: "An Introduction to Starting a Forensic Practice," organized by Dr. Chowallur Chacko, M.D. *Pacific Conference Suite F, fourth floor, Marriott*
4 p.m.-15 p.m.	Committee meeting *Verona, third floor, Renaissance Parc 55*

Wednesday, May 21

9 a.m.-10:30 a.m.	APA's George Tarjan Award Lecture: Prakash N. Desai, M.D. *Rooms 130-131, exhibit level, Moscone Center*

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annual meeting

Body Sculpting: When Perfect Isn't Good Enough

What makes outstanding athletes think that their finely chiseled bodies are never "good enough"?

Highly competitive athletes usually look the part: Their years of training have resulted in well-developed muscles and chiseled bodies devoid of the unsightly fat that many Americans carry around.

So why do some athletes appear to be blind when it comes to seeing how they look in a full-length mirror and think they need to lift more weights, run more miles?

This and other questions will be discussed in a symposium to be held at APA's 2003 annual meeting in San Francisco titled "Pathological Body Sculpting in the Athlete." The symposium, sponsored by the International Society for Sport Psychiatry (ISSP), will be held Monday, May 19 from 2 p.m. to 5 p.m. in room 106 on the exhibit level of the Moscone Center.

The ISSP's vice president, Antonio Baum, M.D., will chair the session. Speakers include Harrison Pope, M.D., of McLean Hospital in Belmont, Mass., who will present his most recent research on anabolic steroid abuse.

Jon-Jon Park, a former professional body builder and Olympic swimmer and current athletic trainer (formerly the trainer of professional boxer Oscar de la Hoya), will talk about his knowledge of anabolic steroid abuse through the world of body building.

Joan Ryan, a journalist for the *San Francisco Chronicle*, will talk about the article she was researching that led her to write *Little Girls in Pretty Boxes*. This book is an account of eating disorders and other difficulties that befall young elite gymnasts and figure skaters. Ryan will discuss in detail one particularly compelling and disturbing case.

Kathy Johnson, a former Olympic gymnast who suffered from an eating disorder, will describe her experiences.

Baum, a professor of psychiatry at George Washington University, will discuss eating disorders in men athletes. She will interview a successful wrestler who lived the subculture of the sport—part of which was significantly disordered eating behavior. ■

HIV/AIDS Sessions Will Provide In-Depth Update

This popular series of sessions will provide information on a broad spectrum of clinical challenges related to the treatment of patients with HIV/AIDS.

APA's Office of HIV Psychiatry and Committee on AIDS will offer several HIV/AIDS-related programs both for psychiatry residents and psychiatrists from various backgrounds and experiences. Each program will provide current information on HIV/AIDS and the central nervous system. This year presenters will aim to provide concrete and practical suggestions for the care of HIV-infected patients. All the programs will provide a forum for psychiatrists to discuss individual clinical cases.

Sunday, May 18, noon to 4:30 p.m.

• **Resident's Program:** The Committee on AIDS will again present a program designed for psychiatric residents. The program will provide up-to-date information on the most important things you need to know about HIV psychiatry. The program will include segments on differential diagnosis and psychopharmacology, as well as case discussions.

Tuesday, May 20, 9 a.m. to 10:30 a.m.

• **Psychiatric Management of HIV, Hepatitis C, and Substance Abuse:** This Committee on AIDS component workshop will offer guidelines for the differential diagnosis of HIV-infection. Presenters will focus on co-occurring HIV/AIDS and hepatitis C, as well as co-occurring HIV/AIDS and substance abuse. Each presentation will provide psychiatrists with tools for evaluating and treating patients along with strategies to provide optimum patient care.

Wednesday, May 21, 2 p.m. to 5 p.m.

• **Neuropsychiatric Aspects of HIV/AIDS: An Overview, Part 1:** This session is the first of two symposia designed to provide a full clinical update for psychiatrists. Part 1 will provide an HIV treatment update and information on CNS complications. An expert clinical panel will present case examples, provide sample treatment options and management strategies. Participants have the option to follow all three segments of the symposium in their entirety or sit in on one segment only.

Thursday, May 22, 2 p.m. to 5 p.m.

• **Neuropsychiatric Aspects of HIV/AIDS: Evaluation and Treatment, Part 2:** This session, to be followed in its entirety or as three separate sessions, is intended to provide psychiatrists with practical suggestions in the clinical care of the

please see ***HIV/AIDS Sessions*** *on page 55*

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Hello Electronic Medical Records, Farewell Paper Charts

BY FATIMAH ANN TAHIL, M.D., M.P.H.

This article presents my experiences with an electronic medical record (EMR) system in a psychiatric outpatient setting. My comments will be limited to the pros and cons of an EMR system from a resident user's point of view.

Access to information in our daily lives has been redefined and simplified, an expectation of living in the 21st century. As such, one would reasonably expect that patients' medical charts be computerized, given the recent advances in information technology. Like the paper version of the medical record, the computerized chart serves the same purpose—a communication tool to document and share information concerning a patient's contact with health care professionals and the treatment received. Unfortunately, acceptance of the electronic medical record in psychiatry has been slow, regardless of the practice setting—inpatient, outpatient, private, or academic.

The mere mention of paper-based patient records (PBPR) conjures an unwieldy mammoth sheath of papers, as well as a sense of foreboding. The thought of combing through PBPRs to familiarize oneself with an "inherited" panel of patients from a graduating senior resident is daunting. The frustration at the disorganized information in the chart is minimal compared with the illegible penmanship by myriad clinicians. Journeys to the chart room to retrieve and return PBPRs are wasteful, especially when the unavailable chart has been signed out to another clinician.

My introduction to an electronic chart in psychiatry occurred almost two years ago. An EMR system was implemented shortly after I began my adult outpatient rotation. Despite the many disadvantages of the standard paper-based chart, its replacement was initially met with dread. Many residents cited anxiety with an unfamiliar medical record format; others acknowledged deficiencies in their typing or computer skills. For the technophiles, or "techies" like me, adapting was fun, exciting, and relatively easy compared with the challenges for the technophobes. From my perspective as a resident, the EMR possesses several distinct advantages over its paper-based version. These include the following:

• **Chart accessibility and retrieval:** A key feature of the EMR is its accessibility. Depending on how the system is designed, it can be accessed from anywhere, locally or remotely, 24/7 with just a few keyboard strokes. Furthermore, the EMR's multiuser capability allows for simultaneous use by two or more clinicians—one with the ability to write in the chart and the others with read-only access.

• **Accurate and legible notes:** Illegible handwriting of clinicians, a common, longstanding problem in PBPRs, becomes a nonissue with the EMR. Legible, neat notes are a welcome feature to any clinician seeking specific patient information. Additionally, the option of printing of nonnarcotic prescriptions directly from the patient's EMR minimizes medication errors.

• **Availability of an organized chart:** In a PBPR, the tedious page-by-page search for specific information, such as medication changes, is circumvented because the EMR is organized for effortless information retrieval. Historical reference in monitoring the patient's progress with treatment is simple. While it may be challenging to the clinician to record all the information mandated by adherence to good medical practices, as well as compliance to state and federal regulatory codes and accreditation standards, the task is accomplished easily in the EMR.

• **Continuity of care and accountability:** The EMR's "Note" function facilitates the effortless exchange of information not only between the multiple disciplines but also various clinicians within each discipline. In addition, the availability of the information in an emergency room or outpatient or inpatient setting enhances the continuity of care.

• **Security and electronic signatures:** The Health Information Portability and Accessibility Act (HIPAA) mandates safeguards for the protection of patient medical information. The EMR, as a password-protected system, controls access to patients' confidential records and provides additional protection of the records. Privacy is further maintained with security controls that track access to patients' information.

Today's EMR system is far from perfect, but its dynamic character and inherent ability to be customized to accommodate new data elements or formats as necessary are a major benefit. These are some of the other

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Dr. Tahil is the chief resident in psychiatry at St. Luke's-Roosevelt Hospital Center in New York City. She holds master's degrees in medical informatics and public health.

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Can Better Diet Prevent Antisocial Behavior?

When children from an impoverished background receive adequate nutrition, increased exercise, and an educational boost, it may keep them from engaging in antisocial behavior later.

BY JOAN AREHART-TREICHEL

A few months ago, C. Bernard Gesch of Oxford University and coworkers reported in the *British Journal of Psychiatry* that vitamin-mineral-essential fatty acid supplements appeared capable of dampening violence in a prison population (*Psychiatric News*, October 2, 2002). However, J.S. Zil, M.D., J.D., chief forensic psychiatrist of the State of California Department of Corrections, told *Psychiatric News* that he was skeptical of their results. To which Gesch replied: "I don't feel that Dr. Zil's cynicism is a problem. It's only natural to be cautious about such provocative findings."

And now here comes another study with similar thought-provoking results. It suggests that taking nutritional supplements during childhood might reduce antisocial behavior later.

The study was headed by Adrian Raine, Ph.D., a professor of psychology at the University of Southern California and a scientist noted for exploring the brain biology of criminals (*Psychiatric News*, March 3, 2000). Raine reported the investigation at the 9th International Congress on Schizophrenia Research, held recently in Colorado Springs, Colo., in a session on the neurobiology and management of violence in schizophrenia. The study is also in press with the *American Journal of Psychiatry*.

This study, Raine explained, took place on a tropical island where the standard of living was quite low. It included 176 3-year-old children. Half the children served as a control group and received, from ages 3 through 5, their usual diets, usual exercise, and usual education. The other half served as an experimental group and received good nutrition, increased exercise, and an educational boost. The educational boost consisted of efforts to improve verbal skills, visuospatial skills, visuomotor coordination, creativity, conceptual skills, memory skills, and sensation and perception.

E. Fuller Torrey, M.D.: "Something is going on in these children."

Adrian Raine, Ph.D.: "It could also be that it's physical exercise, not better nutrition, that is the active ingredient."

Raine and his colleagues then tested the subjects for conduct disorder when they reached 17 years of age and found that there was significantly less conduct disorder in the experimental group. They also found that this effect was especially prevalent in the experimental subjects who had been malnourished at the start of the study.

Raine and his coworkers again assessed subjects for criminal behavior at age 23. Self-reported crime was significantly reduced, by about 34 percent, compared with the control group. There was a trend for official crime to be statistically reduced to about a third of the levels of the control subjects.

Thus, environmental enrichment appeared to reduce the incidence of conduct disorder, and perhaps also of criminal behavior, in these disadvantaged children, Raine and his colleagues concluded.

Peter Buckley, M.D., chair of psychiatry at the Medical College of Georgia and chair of the congress session, described the results as "provocative." E. Fuller Torrey, M.D., of the Stanley Medical Research Institute in Bethesda, Md., the discussant for the session, said, "Something is going on in those children."

The question is, of course, what?

Raine told *Psychiatric News* that the educational boost given the subjects may have made a difference. He also said, however, that he suspects that education is not the explanation since "past attempts [at using education to prevent antisocial behavior] have not been very successful in producing long-term change."

He said that exercise may have made a difference, since Salk Institute scientists recently found that rodents that exercised early in life had enhanced growth of neurons in the brain's hippocampus.

And how about nutrition? This is the explanation that Raine favors, particularly fatty acid supplementation. The experimental group ate lots of fish, he noted. Fish are rich in omega-3 and omega-6 fatty acids, and these acids influence the levels of serotonin and dopamine and are deficient in violent offenders. ■

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Infancy Not Too Early For MH Interventions

Psychiatrists and mental health professionals are intervening with infants and young children to reduce the likelihood of their developing long-term mental health problems.

BY CHRISTINE LEHMANN

Absorbed in his own world, 10-month-old "Tommy" stares into space and rubs the same spot on the family-room rug over and over. He can barely sit up and shows no emotional reaction when his parents talk to him, touch him, or try to interest him in games and toys.

Concerned, his parents seek professional help and are told that Tommy may have the early warning signs of autism or mental retardation. He is referred for evaluation to child psychiatrist Stanley Greenspan, M.D., in Bethesda, Md.

"Tommy had a nervous system that underreacted to environmental stimulation," Greenspan told *Psychiatric News*. "I have also seen some infants with overreactive nervous systems in my practice. If the reactivity is extremely low or high, the infant can have social, emotional, cognitive, and language difficulties. This may also put them at increased risk of having attentional, learning, autistic-spectrum, and mood disorders."

Greenspan, who specializes in infant and early childhood mental health, has written several books on children with special needs, including one on children with bipolar patterns. He cofounded the national organization Zero to Three in 1977 and the international Interdisciplinary Council of Developmental and Learning Disorders (ICDL) in 1995. He serves on the board of directors of Zero to Three and chairs ICDL in Washington, D.C.

Greenspan has observed three patterns of behavior in infants with overreactive nervous systems. "There is the infant who is easily distracted, irritable, and moody, and the infant who is inhibited, anxious, and tense. A third type of behavior emerges when the infant who is anxious and very cautious attends preschool, for example, and encounters a lot of noise and commotion. It's as if a switch is flipped in the child's nervous system, and the child becomes hyperactive, aggressive, and agitated," he said.

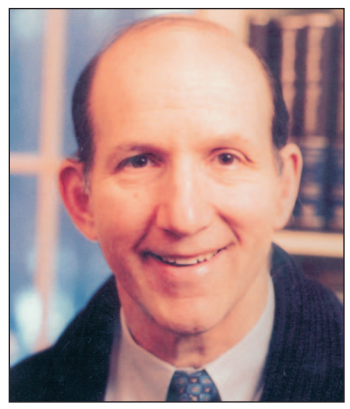
"This switch in the child's moods and behaviors, depending on circumstances, may be a risk factor for developing bipolar patterns, but we need to do more research to confirm our hypothesis."

Infant mental health specialists work in a variety of settings including neonatal units, homes, and outpatient clinics. Zero to Three defines the infant mental health field as encompassing the first three years of life, while many infant mental health specialists define the field more broadly to include parenthood and infants until the age of 5.

"We know that the child's nervous system is still developing in the first five years of life, which makes infant mental health [care] the ultimate in prevention," said Greenspan. "The earlier we can intervene, the greater the likelihood of decreasing the risk of early warning signs becoming significant problems."

The approach used with Tommy typifies how specialists in this field work with young at-risk children. Greenspan evaluated Tommy's neurological, cognitive, and psychosocial functioning and his interaction with his caregivers and family. He developed a profile on Tommy using his Developmental, Individual Difference, Relationship-Based (DIR) model and tailored a treatment plan to fit the profile.

"Tommy had not mastered the first two stages of our DIR model, which are the ability to relate to his caregivers with some warmth and trust and engage in purposeful activity, so that was our first goal," said Greenspan.



Stanley Greenspan, M.D.: "We know that the child's nervous system is still developing in the first five years of life, which makes infant mental health the ultimate in prevention."

An important part of Greenspan's approach is to work on the child's level. For example, Greenspan got on the floor of his office with Tommy and his parents and experimented with how to engage Tommy by interrupting his compulsion. He started by putting his hand on the spot Tommy was rubbing to see whether he would respond. When Tommy moved Greenspan's hand, Greenspan asked the parents to do the same thing.

"We progressed from there to the mother laying her head on the same spot, and Tommy touched her face. She then made cooing sounds and gestures, which Tommy responded to and imitated, initiating reciprocal communication. In a few months, Tommy mastered the first two developmental stages and lost interest in his compulsive rubbing," said Greenspan.

He continued to meet with Tommy's parents to guide them in helping Tommy master each subsequent stage of development in the DIR

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Depression-Serotonin Link: Many Mysteries Remain

Researchers are refining serotonin-challenge studies with an eye toward using them to identify individuals with depression at risk for relapse, much as a glucose-tolerance or treadmill test is used to identify patients at risk for diabetes or heart disease.

BY MARK MORAN

"Challenge" studies testing the effects of serotonin depletion in healthy and depressed subjects continue to suggest a role for the neurotransmitter in depression that is far more complex than the simple deficiency assumed by researchers in the past.

Instead, researchers say, those studies—in combination with neuroimaging and genetic studies—point to a complex neuronal circuitry regulated by many different neurotransmitters and neuropeptides, including serotonin, that interact with each other.

"Our understanding of how serotonin works in depression is much more refined than a simple deficiency hypothesis," said Dennis Charney, M.D., chief of the mood and anxiety disorder research program at the National Institute of Mental Health. "However, there continues to be an enormous amount of evidence that points to an abnormal regulation of the serotonin system in depression. The job now is to look at the different receptor systems and different genes to be more precise about how serotonin interacts. There are many roads to depression, and the circuits are complex."

Pedro Delgado, M.D., chair of psychiatry at University Hospitals (UH) of Cleveland and Case Western Reserve University School of Medicine, has been involved for nearly two decades in serotonin-challenge studies—in which levels of serotonin are depleted or stimulated—to study the effects and their relation to depressive symptoms.

Delgado said that he believes those studies show that serotonin deficiency alone cannot account for depression and that in many cases the actual causes are likely to be "downstream" in some as-yet-undiscovered dysfunction within the very cells of that neuronal circuit.

"One of the summary points is that people who don't have a history of depression don't develop depression during serotonin depletion," he said. Moreover, depressed people who are not treated with antidepressants don't get any worse when challenged with depletion.

More to Relationship

Importantly, however, it appears that depressed patients taking SSRIs—which selectively block the reuptake of serotonin—are affected by depletion. "Whatever the illness of depression is, it is not due to a deficiency of neuroepinephrine, dopamine, or serotonin," said Delgado. "But at the same time the research strongly supports their importance in the mechanism of antidepressants that block reuptake of those neurotransmitters. The unanswered question is, Why do some people become depressed when serotonin is low, while others with low serotonin levels remain depression free?"

Delgado and colleagues at UH are extending the work of serotonin-challenge studies with an eye toward using them to identify those individuals for whom serotonin levels are influencing mood regulation—much like a glucose tolerance or treadmill test to identify patients at risk for diabetes or heart disease.

"We believe that the serotonin-depletion procedure might be used to predict when patients no longer need medication," Delgado told *Psychiatric News*. "We also hope to identify those people who, though they never had depression, are at increased risk for it in the future."

Tryptophan Depleted

In the study at University Hospitals of Cleveland, Delgado and colleagues will induce a reduction in serotonin levels in healthy participants and in individuals who have previously suffered from depression by depleting natural stores of the amino acid tryptophan.

Delgado explained that a considerable body of research has shown a correlation between levels of tryptophan—one of the naturally occurring amino acids essential to the building of protein—and levels of serotonin. "Serotonin levels change within 30 minutes to two hours of tryptophan depletion," he said. "There is a very tight correlation."

Depletion of the body's store of tryptophan is accomplished ingeniously. Subjects imbibe a drink consisting of 16 essential amino acids but lacking in tryptophan. When the amino acids are ingested, the body begins to put them together into proteins.

"You are actually driving the synthesis of protein," he said. "But if you leave out any one of the essential amino acids, the body will extract the missing amino acid from its own serum."

Thus, the body's own stores of tryptophan are depleted, causing a concomitant depletion of serotonin. "You can reliably cause a depletion of tryptophan by 90 percent within five hours," he said.

But can researchers ethically induce in volunteers the depletion of a naturally occurring chemical believed to be involved—however indirectly—with depression?

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Such questions invariably adhere to challenge studies, which came under increasing scrutiny in the last decade when safety issues arose around studies looking at the effects of medication-abatement in schizophrenia. But Delgado says that 20 years of serotonin-challenge studies—and their results essentially refuting the hypothesis that diminished serotonin levels alone are the cause of depression—have proven the tryptophan-depletion strategy to be hazard free.

"From an ethical perspective, this procedure is relatively safe and well tolerated. Tryptophan depletion most often doesn't cause any clinical change in mood, and when it does, the symptoms are quickly and easily reversible," Delgado said.

In a study published in the May 1990 *Archives of General Psychiatry* looking at the effects of serotonin depletion, Delgado said he and colleagues at Yale University looked at 100 patients who had been treated successfully with antidepressant medication of different kinds. They found that following serotonin depletion nearly 80 percent of those patients became transiently depressed, which was quickly and easily reversible.

Curiously, too, they found that the depressive symptoms were highly idiosyncratic. "The symptom profile that reemerged during the depletion was unique to the person," Delgado said. "It wasn't as though they had some nonspecific syndrome."

The observation seemed to suggest that serotonin depletion wasn't the cause of depression per se, but likely had some role in the regulation of mood in individuals being treated for depression.

The findings were underscored in a study published in the November 1994 *Archives of General Psychiatry*. This time the researchers looked at a much larger sample of patients with depression who had never been treated with antidepressants.

And what they found was that depletion of serotonin did not make depression worse—though there did appear to be a "day after" effect in which a small subset felt somewhat worse. The import of the studies was clear: though serotonin level had something to do with regulating mood, it wasn't the cause of depression.

Delgado likens the flaw in the serotonin-deficiency hypothesis to the error in reasoning that assumes the sun rises because the cock crows. "If you have a rash," he said, "and use some corticosteroid cream and it gets better, [using the same reasoning] you would come to the conclusion that it was a deficiency in corticosteroid that causes a rash."

"There are many roads to depression, and the circuits are complex."

But Charney noted that serotonin-challenge studies combined with genetic research and neuroimaging do underscore a central role for serotonin in depression. And he said that in at least some patients a reduced number of certain receptor subtypes for serotonin might be crucial.

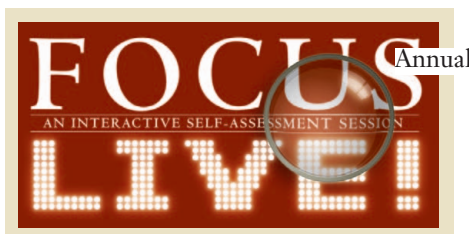
"Depression is a heterogeneous disease," Charney told *Psychiatric News*. "We are identifying a circuitry that involves different brain regions that mediate different facets of depression. And we are identifying how different transmitters and neuropeptides regulate those circuits."

Charney said that positron emission tomography scans of the brain have shown that one serotonin receptor subtype in particular—the 1A receptor—appears to be prominent. "A number of imaging studies have shown that depressed patients have a reduced number of 1A receptors," he said. "Even patients in remission seem to have a lower number."

Preclinical studies also bear out the hypothesis. "If you take away the serotonin 1A receptor in mice using genetic techniques, the animals develop a phenotype of depression," Charney said.

Researchers agree that what once appeared to be a straightforward correlation between serotonin levels and depression now presents itself as a far more richly nuanced and dynamic process.

Delgado believes that in many cases science will have to look for the causes of depression in the intracellular dysfunctions of neurons themselves. "Whatever the illness of depression is, in many cases it has to do with cellular dysfunction in neurons that make up the circuits that regulate mood," he said. "The neurotransmitters may help to modulate those circuits and seem to be important in sustaining their connectedness." ■



Annual Meeting

Earlier this year, APA launched a new journal, *FOCUS, The Journal of Lifelong Learning in Psychiatry,* whose purpose is to help psychiatrists stay up to date on the latest information on a wide range of psychiatric disorders and maintain board certification. To complement the journal, a new format, appropriately titled "Focus Life," has been added to the annual meeting program.

This format is composed of two sessions on the same topics covered, respectively, in the first two issues of *FOCUS*. The first "Focus Live" session, which deals with bipolar disorder, will be held on Tuesday, May 20, at 9 a.m. in room 106 on the exhibit level of the Moscone Center. The second session, on substance abuse, will be held that same day in the same location at 11 a.m. Both will be cochaired by Deborah Hales, M.D., director of APA's Division of Education, Minority, and National Affairs, and Mark H. Rapaport, M.D.

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NSAIDs and Amyloid Plaques Have Close Relationship

New images indicate that nonsteroidal anti-inflammatory drugs may indeed be very helpful in breaking up the amyloid plaques that are a hallmark of Alzheimer's disease.

BY JIM ROSACK

New imaging data may help explain why nonsteroidal anti-inflammatory drugs (NSAIDs) seem to lower the relative risk for developing Alzheimer's disease (AD).

To the surprise of researchers, two of the most common NSAIDs appear to bind directly to the amyloid plaques that are an anatomical hallmark of AD, and evidence indicates the drugs not only prevent further deposit of amyloid, but may actually break up existing plaque.

Several previous studies have indicated that AD is less prevalent in persons taking NSAIDs, said Gary Small, M.D., Parlow-Solomon Professor of Aging and professor of psychiatry and biobehavioral sciences at the University of California at Los Angeles.

"The question is," Small told *Psychiatric News*, "how does that happen?"

Researchers and clinicians have postulated, Small said, that the people who take NSAIDs are typically more active and are taking the drugs for joint pains. The AD benefit gained, he said, could be related to those individuals' better-than-average physical conditioning. "But there's really no evidence yet to sort all of it out," he noted. Others believe that the reduction in the prevalence of AD is a direct effect of reducing inflammatory processes in an Alzheimer's-diseased brain.

Gary Small, M.D.: "Our study suggests an alternate mechanism for how these drugs might affect the disease."

"Clinical trials using these drugs in [patients who already have] Alzheimer's disease have been negative," Small added. "What we don't know yet is how the placebo-controlled trials that are preventive in nature will come out."

The largest such trial, the National Institute on Aging's Alzheimer's Disease Anti-Inflammatory Prevention Trial (ADAPT) is recruiting patients. Results from that trial are still years away.

Small and his colleagues took tissue from known Alzheimer's-diseased brains and added two NSAIDs—naproxen and ibuprofen—and then added the chemical marker FDDNP. The marker was developed at UCLA to bind specifically to amyloid plaques to image the pathological lesions using PET scans (*Psychiatric News*, December 21, 2001).

What they found, Small said, was that the drugs directly bound to the amyloid-plaque formations. Additional test-tube studies with FDDNP, synthetic amyloid, and the two NSAID drugs showed that the drugs actually may dissolve the plaques and even inhibit new plaque formation.

Small and principal author Jorge Barrio, M.D., professor of molecular and medical pharmacology at the David Geffen School of Medicine at UCLA, published their report in the March 31 issue of *Neuroscience*.

"I think what is interesting and novel about our study," Small said, "is that it suggests an alternate mechanism for how these drugs might affect the disease." If you could actually look at an amyloid plaque, Small explained, "what you'll see is that there is a core plug consisting of insoluble amyloid protein and around it are elements of inflammation. The thinking was that the insoluble amyloid accumulates in the brain, and then the brain tries to get rid of it through an inflammatory response. We already know that there's something about that inflammatory response that is toxic to neurons, so let's just get rid of the inflammatory response."

It might not be all that straightforward, if Small's data pan out. "It may not be the way that they are working at all," he continued. "The NSAIDs may be getting into the insoluble amyloid core and preventing amyloid from aggregating or even dissolving what's already there."

He noted, however, that there is no evidence that getting rid of existing plaques will improve a patients clinical outcomes. Some researchers suspect that by the time an actual plaque is formed, the damage has occurred and cannot be repaired. What Small thinks is more exciting is the possibility that NSAIDs could prevent the original buildup of the plaques.

"These studies suggest a previously unsuspected way in which the nonsteroidal anti-inflammatory drugs may interact with Alzheimer's amyloid," agreed ADAPT principal investigator, John Breitner, M.D., professor and head of the division of geriatric psychiatry, psychiatry, and behavioral sciences at the University of Washington in Seattle. "They also show that different drugs in this class may have different effects on amyloid. Clearly, we have a great deal to learn about the way in which these drugs

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Clues to Shyness May Lie in Our Genes

A gene variant that has been linked with anxiety in the past is implicated in shyness as well. It is a variant of a gene that influences serotonin production.

BY JOAN AREHART-TREICHEL

Pity the little boy who would like to join others in building a structure out of Lego blocks, yet who doesn't trust himself to do so. He can undoubtedly blame his feelings, at least in part, on his genes.

The reason? Israeli scientists have linked shyness in children with the inheritance of a particular gene variant. The finding was published in the April *American Journal of Psychiatry*.

Shoshana Arbelle, M.D., a lecturer in health sciences at Ben-Gurion University's Soroka Medical Center, Richard Ebstein, Ph.D., a professor of psychology at Hebrew University, and coworkers assessed shyness in some 100 second-grade children, using a composite scale derived from questionnaires given not just to the children, but to their parents and teachers. They found significant correlations between the ratings of the children, parents, and teachers concerning which children were shy and which were not.

The researchers then took DNA samples from the children and examined them for the presence of variants of four genes that are "hot" in human behavioral genetic studies these days. They are the 5-HTTLPR gene (for serotonin transporter promoter region 44 base pair insertion/deletion), DRD4 gene (for dopamine D4 receptor exon III repeat), COMT gene (for catechol O-methyltransferase), and MAO A gene (for monoamine oxidase A promoter region repeat).

The scientists then looked to see whether they could make a statistically significant link between subjects with high shyness scores and the possession of various variants of these four genes. They could for one variant of the 5-HTTLPR gene, but not for the other variants.

This finding is probably not surprising. The variant of the 5-HTTLPR gene that they connected with shyness has also been found in the past to be implicated in anxiety.

The finding has drawn a comment from the co-discoverer of the double-helical structure of DNA, Nobel laureate James Watson. The April *American Journal of Psychiatry* commemorated the 50th anniversary of the discovery of the double helix, and Watson provided a commentary in the issue. In this commentary, he wrote that he and co-discoverer Francis Crick realized that theirs was a "pivotal discovery" when they published it in *Nature* in 1953. Yet they had no idea, Watson admitted, "what richness" would flow from it in ensuing years. And one example, he pointed out, is this finding of what appears to be a shyness gene for children.

The study was financed by the Israel Ministry of Health and the Israel Science Foundation.

The study, "Relation of Shyness in Grade School Children to the Genotype for the Long Form of the Serotonin Transporter Promoter Region Polymorphism," is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/160/4/671?>. ■

residents' forum

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practical shortcomings to the EMR that I have encountered:

• **Nonintegration of medical laboratory and other clinical data:** A patient's overall health is reflected in a medical record through the inclusion of annual physical exams and pertinent clinical laboratory data (example, lithium blood levels). A limitation of the EMR is the absence of integration or linkage of these data stored within other computerized systems. Regrettably, the consequence is a fragmented and incomplete electronic patient record.

• **Failure to include a patient's original documents and correspondence:** Documents and correspondence to and from the patient are part of the patient's PBPR, but are not included in the EMR. Instead, they remain part of the paper-based record. As technology improves, however, these hard-copy documents could be linked to the EMR using multimedia techniques to achieve a more comprehensive patient record.

• **System crashes:** A very rare but paralyzing moment occurs when the computer system crashes, and one is left with no chart during the visit. The design and installation of electronic backup systems and procedures assure that if such an event occurs, data retrieval is possible with minimal loss of data.

Overall, despite the anxiety-filled transition toward an electronic patient chart, I still choose the legibility, organization, and accessibility an EMR offers. So far, I have managed to integrate it into my daily practice as a resident. My exposure to the EMR leaves me hard-pressed to even consider practicing in a setting without the availability of this technology. ■

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Psychiatry in War

BY LUCY OZARIN, M.D.

The United States has engaged in 10 major wars since its founding, with psychiatry first becoming involved—or trying to become involved—in military combat during the Civil War.

In 1864 the Association of Medical Superintendents of American Institutions for the Insane (now APA) held its annual meeting in Washington, D.C., and the superintendents who called upon President Lincoln were "cordially received." Charles Henry Nichols, M.D., the superintendent of the Government Hospital for the Insane (now St. Elizabeths Hospital) and acting assistant surgeon during the Civil War, was appointed to meet with the Army surgeon general to offer the assistance of the Association to care for the wounded in Fredericksburg, Va. The written reply gave thanks, but "until a more urgent necessity makes it advisable," help was not then needed.

Psychiatry's interest in military matters arose again during World War I (1914-18). Thomas Salmon, M.D., medical director of the National Committee of Mental Hygiene (now the National Mental Health Association), became concerned about reports of psychiatric war casualties and went to England to see how they were being managed. He joined with Pearce Baily, M.D., and Stewart Paton, M.D., to form an advisory committee to the surgeon general of the Army, which led to the establishment of a neuropsychiatry unit in the surgeon general's office and preparation of a program for psychiatry in the Army.

When America entered the war in 1917, Salmon was appointed chief of psychiatry for the Army overseas. The psychiatric program went into effect and included screening of recruits, assignment of senior psychiatrists as consultants to Army divisions, establishment of base hospitals close to the front, and psychiatric units in general hospitals.

Psychiatric casualties were treated with the principles of immediacy, proximity to the war front, simplicity (rest, recreation, occupation), expectancy (return to active duty), and centrality (a central screening point prior to evacuations). The program was successful in returning to duty many soldiers who had suffered from "shellshock" and traumatic neuroses.

When the United States entered World War II in 1941, the psychiatric lessons gleaned from World War I had been forgotten and thus had to be relearned. The William H. White Foundation, a psychoanalytic group in Washington, D.C., with Harry Stack Sullivan, M.D., proposed guidelines for Army inductees that were later modified by the Selective Service System. APA became actively involved. A neuropsychiatric unit in the surgeon general's office was again activated, with Roy Halloran, M.D., and later William Menninger, M.D., in charge.

The small number of psychiatrists available for active duty was supplemented by general practitioners who were given brief psychiatric training (many entered psychiatry residencies after the war). Salmon's principles were again put in place to treat what was termed combat or exhaustion fatigue. The importance of morale and unit cohesion was demonstrated.

The Korean War (1950-53) also used Salmon's principles under the leadership of Col. Albert Glass, and once again success in returning a large proportion of psychiatric casualties to active duty was achieved.

The Vietnam War (1961-73) was a different type of war fought in a different way from previous wars. Also different was the emergence of psychiatric casualties after the war. Posttraumatic stress disorder with symptoms of hyperarousal, intrusion, and avoidance affected many veterans, who were treated in special units of the Veterans Administration. Also encountered during the prolonged conflict were psychoneurotic symptoms, disciplinary infractions, and drug abuse among the support troops attributed to a lack of social supports and unit cohesion.

Psychiatric casualties during the brief first Gulf War (1991) were small in number, but a new entity called Gulf War syndrome emerged with psychosomatic components such as fatigue and lack of concentration. No adequate explanation about its etiology has yet been agreed upon.

The United States is again engaged in war in 2003. Psychiatry is taking an active role drawing on experiences of the past, and *Psychiatric News* will report on psychiatry's latest contributions in this arena in future issues. ■

Liability

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"Before you can heal the patient, first you have to stop the hemorrhaging," said Coble. "We strongly urge the Senate to pass common-sense medical liability reform legislation that will preserve patients' access to care. The AMA will continue to work with patients, physicians and lawmakers at the grass-roots and national levels to pass medical liability reforms until this crisis ceases to exist."

Beyond stemming the immediate crisis, Coble said the nation needs to turn its attention to building a system that encourages medical safety and eradication of errors. He said the Patient Safety and Quality Improvement Act (HR 663), currently in the House of Representatives, would encourage a "systems" approach to fixing medical errors, replacing the current system of "blame and shame." ■

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Youth Violence

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the vignettes—often developed into candid discussions of someone's child who was combative at school, belonged to a gang, or was bullied by other children in the classroom.

Bullying was a frequent theme of these discussions, Colón de Marti noted. "One of the parents began crying when she read the vignette because she believed we were writing about her child."

The mother came to the workshop to learn more about how to help her daughter, who suffered from a congenital disease that caused her to look different from other children. The girl had long been the victim of merciless bullying at the hands of her classmates.

The residents instructed the mother about how to get help for herself and her daughter and provided the teachers in the group with strategies to stop the bullying in the classroom.

According to psychiatry resident Gloria Suau, M.D., who led some of the smaller group sessions, "The workshops not only helped us to understand our role in the community, but also helped the community to understand the role of mental health professionals and the different mental health services available to them."

Some didn't know the difference between a psychologist and a psychiatrist, for instance, or under what conditions inpatient hospitalization as opposed to outpatient care was warranted for a child with mental health problems, Suau said.

At each workshop, residents and faculty came armed with a list of local agencies, hospitals, and psychiatrists and mental health professionals that the parents and teachers could turn to for children in need of help.

Sometimes, the faculty and residents were the ones who helped the children through their crises.

Suau shared one particularly rewarding experience that came out of the workshops. There, she met the mother of a young girl with mood swings and frequent and explosive temper tantrums. She was teased by her schoolmates because of her obesity.

Suau evaluated the girl and found that she had Prader-Willi syndrome, a genetic disorder characterized by short stature, below-average intelligence, aggressive tendencies, obesity, and obsessive behavior often involving food.

At the university's outpatient clinic under supervision of faculty, Suau began behavior and medication therapy. She then referred the child to a number of specialists, including a nutritionist, who helped her control her eating, and an endocrinologist, who started the girl on a growth hormone—growth hormone has the double benefit of facilitating growth and controlling mood swings. Another specialist treated her for sleep apnea. In addition, Suau created a brochure to educate children about Prader-Willi syndrome and united parents of other children with the syndrome, who went on to launch a support group.

"The child rarely has temper tantrums, and her mood swings are under control," Suau said. "She is more alert and does better in school."

The psychiatry residents have benefited as well from the experience. "The workshops have improved our professional skills and enriched our training. It's been an excellent learning experience," Suau said. ■

Annual Meeting

Post-Holocaust Film To Be Discussed

The award-winning 1996 film "Under the Domim Tree" will be the focus of two sessions at this year's annual meeting in San Francisco.

The film will be shown on Monday, May 19, at 7:30 p.m. at the Delancey Street Screening Room at 600 Embarcadero, a short walk from the Moscone Center. Discussion of the film will begin immediately after the screening and continue the next day at the workshop "Post-Genocide Psychological Trauma in Film," which will be held from 11 a.m. to 12:30 p.m. in room 304 on the esplanade level of the Moscone Center. All annual meeting registrants and their guests are invited to attend both sessions.

The film deals with a group of orphaned teenagers residing in an Israeli kibbutz in the 1950s. During the day they are building a new Israel with the verve and idealism seen in youth. At night, however, they are tortured by memories of their experiences during the Holocaust. Their only solace is found under the domim tree. The film is based on the highly acclaimed autobiography of Gila Almagor, one of Israel's leading actresses.

The discussion will be co-chaired by Harold J. Bursztajn, M.D., of Harvard Medical School and Maurice Preter, M.D., of the University of Mississippi Medical Center. They are both the sons of Holocaust survivors and have done much clinical work with and research on other child survivors.

This event is in part sponsored by the International Trauma Center, a private, nonprofit association. ■

letters to the editor

Making Moral Judgments?

I am writing in response to the article in the March 21 issue with the headline "Court Allows State to Medicate Death-Row Inmate Forcibly."

Do I see a dilemma in the disapproval of treating death-row inmates while advocating the treatment of incompetent individuals to stand trial? What if the trial will lead to a death sentence? Once we make the treatment of our patients dependent on our own moral judgment regarding their fate, don't we put ourselves on a slippery slope? What about the soldier whom we might not want to treat because we might put him at risk to be killed in a war that we consider unjust? What about treating a prisoner about whose recidivism there is no doubt in our minds?

MARIN BAUERMEITER, M.D., PH.D.
Wickford, R.I.

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Alzheimer's

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ordinarily expected, over the six months of the study. The drug greatly slowed their decline, which we hope translates into increased functionality and quality of life, and although we didn't look at it in this specific study, presumably a delay in institutionalization."

Neil Buckhotlz, Ph.D., chief of the Dementias of Aging Branch at the National Institute on Aging (NIA), noted in a press release regarding the *NEJM* report, "This study shows that treatment in the very late stages of Alzheimer's can be beneficial in a number of ways, for both patients and caregivers."

Reisberg's team at New York University coordinated the study, which enrolled 252 patients at 32 medical centers nationwide. A total of 181 patients completed the study, which was funded by the German pharmaceutical company Merz (which discovered memantine), as well as a grant from NIA. (Forest Laboratories holds marketing rights for the drug domestically, pending its approval by the FDA.)

The average age of the patients was 76, and 67 percent were women. All of the patients lived in the community, but while they had trouble with dressing, bathing, toileting, and continence, all patients could still communicate to some degree and were able to walk. The average baseline score on the Mini-Mental State Examination (MMSE) was 7.9.

The study was a randomized, placebo-controlled, stage III clinical trial. Over a period of 28 weeks patients received either 10 mg memantine twice a day, or placebo.

The primary outcome measurements were the global score on the Clinician's Interview-Based Impression of Change Plus Caregiver Input (CIBIC-Plus) at 28 weeks, and the change from baseline to week 28 on the Alzheimer's Disease Cooperative Study Activities of Daily Living Inventory, modified for more severe dementia (ADCS-ADLsev). Assessments were completed at baseline, at week 12, and at completion (week 28) or upon a patient's early withdrawal from the study.

Secondary measures included the MMSE, the Neuropsychiatric Inventory, and scores on the Severe Impairment Battery (SIB) and the Functional Assessment Staging (FAST) scale.

Improvements for patients who received memantine were statistically significant on the ADCS-ADLsev, the SIB, and the FAST and approached statistical significance on the CIBIC-Plus.

Open-Label Extension

In a separate presentation at the neurology meeting, Frederick Schmitt, Ph.D., a professor of neurology at the University of Kentucky and a co-author of the *NEJM* report, detailed data from a 24-week, open-label extension of the 28-week randomized clinical trial.

One hundred and seventy-five patients continued into the second phase. Patients who switched to memantine from the placebo group in the first 28 weeks of the study saw statistically significant improvement. In addition, the benefits seen in the initial 28-week trial for those taking memantine were sustained throughout the 52-week study period, using the same assessment scales.

Combination Therapy

Also presented during the neurology meeting were data on the use of memantine as adjunctive therapy to donepezil (Aricept).

In a study of more than 400 patients in a six-month phase III randomized placebo-controlled clinical trial, the combination of memantine and donepezil demonstrated significant improvement in patients' cognition relative to baseline and as compared with donepezil plus placebo.

Again the patients in this trial had moderate to severe Alzheimer's and used the same outcome measures: CIBIC-Plus, ADCS-ADLsev, and the SIB. Patients taking the memantine-donepezil combination also showed significantly less decline in activities of daily living.

Notably, in each of the studies fewer patients taking memantine dropped out of the trial for adverse events, compared with placebo. The most frequently cited adverse event for those taking placebo was agitation, which was markedly improved in those receiving memantine.

"The results of this combination-therapy study point the way toward a new standard of care in the treatment of moderate to severe Alzheimer's," said Martin Farlow, M.D., lead investigator of the study and a professor of neurology at the Indiana University School of Medicine, during a press conference. "The findings are encouraging since they suggest that memantine's mechanism of action, which is unique and different from cholinesterase inhibitors [such as donepezil], will really let us attack the disease on another front."

A spokesperson for Forest Laboratories, which submitted its New Drug Application to the FDA in January, said that the company expects an action letter from the agency by the end of 2003. If approved, the spokesperson indicated, the drug could be available to patients in the United States by the summer of 2004.

"This drug is really a major advance in two ways," Reisberg concluded. "One, it is the first effective treatment for the severe stages of Alzheimer's, and two, it represents a whole new way to treat neurodegenerative diseases—it is really a first proof of concept."

An abstract of "Memantine in Moderate-to-Severe Alzheimer's Disease" is posted on the Web at <http://content.nejm.org/cgi/content/abstract/348/14/1333>. ■

annual meeting

HIV/AIDS Sessions

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HIV/AIDS patient. The symposium will begin with the presentation "Evaluating the Neuropsychiatric Patient," followed by "Six Things You Need to Know: Drug-Drug Interactions." The symposium will conclude with a presentation on managing depression and anxiety. Participants are invited to ask questions following each lecture.

Saturday to Wednesday, May 17 to 21

• **Resource Center:** Visit the Office on HIV Psychiatry booth at the APA Resource Center in the Exhibit Hall to learn more about the programs and resources available to help you in your training efforts or clinical practice. The exhibit will offer national and local clinical and patient information including books, newsletters, training curricula, brochures, articles and lists of Web resources. ■

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Ruling

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the relationship between state law and federal law."

He added, "The AMA has repeatedly maintained that health insurance companies cannot avoid accountability to state laws regulating insurance by hiding behind a federal law known as [ERISA]. We applaud the Supreme Court for making a clean break from the confusing interpretations previously used by the court to determine appropriate occasions when state law may be preempted by ERISA."

Two-Edged Sword

APA Vice President Steven Sharfstein, M.D., took a slightly more cautious view of the ruling, while acknowledging that it could help increase access to psychiatrists on health plan panels.

"A unanimous opinion of the Court recognizing 'any willing provider' laws should allow psychiatrists to join any carveout networks," he told *Psychiatric News*. "That might be beneficial in some parts of the country. If this leads to more people joining networks, that would be positive. The rub is that in order to become a part of a network, the clinician must still agree to their terms related to care and fees."

He added, "It could be helpful, but it's hard to say. It has happened many years after the involvement of managed care in the lives of patients."

Coming from an entirely different perspective, at least one insurance industry spokesperson agreed as much.

"Today's ruling by the U.S. Supreme Court changes little in the current health care delivery system," said Karen Ignagni, president and CEO of the American Association of Health Plans. "In the nine years since Kentucky's 'any willing provider' legislation was passed, insurers responded to consumer demands, offered more product choices, and built a higher quality health care system. Innovation is the hallmark of this industry, and we will continue to adapt to the interests of consumers and the demands of regulators.

"In a time of rising health care costs, today's ruling underscores the critical need for state legislators to carefully evaluate the consequences of legislation on affordability and quality," Ignagni said. "Polls consistently show that consumers' top health care priorities are enhanced access to affordable coverage and quality."

Choices Limited

Other industry experts, however, had a more negative reaction to the ruling.

"We're extremely disappointed by the Supreme Court's ruling in favor of so-called 'any willing provider' laws," said Donald Young, M.D., president of the Health Insurance Association of America. "These laws are one more instance of government unnecessarily interfering in private relationships between doctors and health plans.

"The requirement for health plans to open their provider networks will result in higher health insurance premiums and the real possibility of diminished quality of care," Young continued. "It is another step for those who believe the government can best determine how health care should be financed and delivered, further limiting choices for health care consumers. Ultimately, it is the American worker who will bear the brunt of this decision." ■

members in the news

Everett

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tioning public mental health traditions in Virginia, which can really raise the hackles of the state's citizens." She adds that being a district branch representative to the APA Assembly has really helped her "learn how community psychiatry is done in other states so that I don't get stuck in the Virginia way!"

Which leads to several of the things which she would still like to accomplish in the position—for example, to see how many seriously mentally ill Virginians have access to evidence-based services in the community and to take patients along to help with inspections. "When we first started," she points out, "we actually hired patients to come and work with us, to talk with other patients and with staff about conditions, but because of funding limitations, it's been a while since we've done that."

"My dream for the office," she admits, "is to have a few more staff members so that we can do some more thorough evaluations. But the current state budget crisis in Virginia won't allow it."

In fact, whether Everett will even be permitted to continue as inspector general is uncertain because her four-year term ended in January, and Gov. Mark Warner has appointed her acting inspector general of the system only until July 1.

Finally, it is even questionable whether the position of inspector general itself will continue to exist, since what the Virignia legislature and governors give, they can also take away.

Whether the position survives for the long haul, however, Everett feels good about what she and her staff have achieved. "I do believe that we have made a difference in patients' lives," she says with a smile.

She hopes that the successes that she and her staff have achieved will inspire other states with inadequate public mental health systems to create an inspector general position of their own. ■

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WYETH SYMPOS
(KELLER)
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GLAXO SYMPOS
(COHEN)
1/2H BW

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from the president

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reliance on investment income and one-time gains to balance our budget, and the benefits of this more prudent approach to fiscal management will be evident in subsequent years. We have used the surpluses of the last two years to begin rebuilding our reserves, which have been hammered by both deficits and a poor investment climate.

Other changes we made in 2002 should set the stage for future improvements in APA functioning as well. Our new medical director, Jay Scully, M.D., has taken charge of our staff with a "can-do" attitude that has brought a new level of energy and enthusiasm to the APA offices. And the offices themselves have moved to bright, efficient, lower-cost space just across the Potomac River from Washington, D.C., in Arlington, Va. Planning is under way for a revamping of APA's antiquated computer systems—a major capital investment that should bring a long-needed improvement in our ability to serve members' needs. In this year's election, our members approved a streamlining of APA's Board that will downsize two positions over the next few years and should improve the Board's deliberative and decision-making functions.

Every balance sheet, of course, has two sides. Despite APA's progress in so many areas, there is no question that much remains to be done. Our procedures for enrolling and transferring members are archaic, serving only as a deterrent to people joining and remaining in APA. Member service is not always what it should be—hence the importance of Dr. Scully's reminders to our staff that the members are the people for whom every staff person works—and, I would add, every APA officer, Board member, and Assembly member too.

No organization, of course, exists merely to perpetuate itself. The ultimate assessment of how we are doing will be based on how well we promote the interests of our patients and our members. With regard to member services, this past year we initiated *Focus*, a new quarterly journal of lifelong psychiatric education, the value of which was evident when the projected subscriber base topped projections by 50 percent even before its second issue appeared; members receive a very substantial discount on *Focus* subscriptions. A free Grand Rounds CME program now appears regularly on the members-only section of our Web site. Also on the Web site is a package of materials designed specifically to help our members deal with the complex requirements of the new HIPAA medical privacy regulations. Preliminary steps are under way for the production of *DSM-V* later in this decade, and we have a task force busily at work on a 21st-century update of our ethics annotations for psychiatry.

On the advocacy front, APA continues to fight psychologist prescribing, with successes in two states—Wyoming and Hawaii—so far this year. A package of materials has been prepared to help members and district branches combat cuts in Medicaid and the introduction of restrictive formularies. My particular focus, as many of you know, has been calling attention to the systematic defunding of psychiatric services in both the public and private sectors, a problem that is only getting worse in the current budget climate. In anticipation of the coming President's Commission report on mental health, a task force I appointed has developed a vision for a revitalized mental health system, which has already received enthusiastic responses in Washington and from our members. Coverage of this plan will appear in a future issue of *Psychiatric News*. (Like so much of the advocacy material APA produces, it too can be accessed on the Web site.)

I just returned from the annual APA-sponsored Academic Consortium, an opportunity for psychiatric researchers and department chairs to advocate with Congress for greater funding for psychiatric research (see article on page 1). And we continue our advocacy work on mental health parity, VA funding, state mental health system funding, and many other areas as well.

That's my take on how we are doing. Many things are going right, but there's no question that there remain challenges to overcome. Ed Koch, of course, had the essential insight that what really matters is how the voter—or in this case, the member—would answer the question.

So tell me what you think. How are we doing? I will pass along your responses to our incoming president, Marcia Goin, M.D., and our medical director, Jay Scully, M.D. After all, they work for you. ■

PP&MC
APA OFFICE OF HEALTHCARE SYSTEMS AND FINANCING

Pharmacy

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three (99XX3) or level four (99XX4) code on the outpatient side or a level two (99XX2) code on the inpatient side. Your documentation must demonstrate the need for that particular level of service.

Send CPT inquires by e-mail to hsf@psych.org or fax to (703) 907-1089.

APA Business Initiative Presses On

"Work is a core indicator of treatment outcome and psychological function, so psychiatrists should assess and understand the relationship between work and identity, work and functioning, and work and relationships," said Steve E. Pflanz, M.D., a member of APA's Committee on Psychiatry in the Workplace. Pflanz listed nine categories of questions for psychiatrists to address: (1) accidents and incidents; (2) absenteeism; (3) timeliness; (4) conflict; (5) performance (6) satisfaction; (7) security; (8) safety; and (9) stress.

See article at <www.psych.org>.

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clinical & research news

Interventions

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model. "I followed Tommy for many years because his problems were severe, while other children I see only require a brief follow-up," said Greenspan.

Infants who are traumatized by being exposed to domestic or community violence or war for example, may show a wide range of symptoms including disrupted sleep and eating patterns, difficulty learning and exploring their environment, and trouble regulating their feelings, said Alicia Lieberman, Ph.D., last month at the Association of Health Care Journalists meeting in San Francisco. Lieberman directs the Child Trauma Research Project at the University of California at San Francisco (UCSF) General Hospital and is a professor of medical psychology at UCSF.

Traumatized infants can also experience emotional distress, immature and regressive behaviors, physical complaints, and loss of certain skills especially language, said Lieberman.

Signs of distress can be seen in babies as young as four months, said Lieberman. They appear sad, withdrawn, afraid, disorganized, and cry easily, said Lieberman.

Posttraumatic stress disorder can be seen in infants aged 2 and older, particularly in extreme cases of trauma, said child psychiatrist Charles Zeanah, M.D., in an interview with *Psychiatric News.* He is a professor of psychiatry and pediatrics and director of child and adolescent psychiatry at Tulane University Health Sciences Center in New Orleans.

Zeanah and Michael Scheeringa, M.D., developed the PTSD Semi-Structured Interview and Observational Record for Infants and Young Children.

Young children may re-experience symptoms of the trauma through rigid, repetitive play, for example, and have increased fears and aggression in addition to PTSD symptoms similar to those seen in adults, according to Zeanah.

"The infant who is exposed to domestic violence may have trouble with attachment because it affects the quality of the primary caregiver relationship. The child may realize that the mother is in trouble and, as a result, may also feel endangered. The infant may also sense that its mother is more preoccupied and less available than before and feel neglected," said Zeanah.

Lieberman said the caregivers may have been traumatized also, but they experienced the trauma differently from the child. "Psychotherapy should include both the child and the parent so they understand each other's experiences and concerns, and so the parents don't retraumatize the child," said Lieberman.

Some of the techniques Lieberman uses in child-parent psychotherapy are play therapy, narrative therapy, modeling protective behaviors, and interpretation of events to link the past with the present.

Information about Zero to Three is posted on the Web at <www.zerotothree.org>, and information about the Interdisciplinary Council of Developmental and Learning Disorders (ICDL) is posted at <www.icdl.com>. ■

NSAIDs

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may prevent Alzheimer's disease. The UCLA work appears to open a whole new avenue of investigation in this important area."

The next step, Small told *Psychiatric News*, is to prospectively use FDDNP and PET scanning in patients who do not yet have AD, but perhaps are at high risk, and treat those patients acutely with naproxen to see if the pictures change. After that, a new treatment trial could include serial scans in patients treated with naproxen to see the long-term effects.

An abstract of Barrio and Small's study is posted on the Web at <www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list—uids=12617976&dopt=Abstract>. More information on the ADAPT clinical trial is posted at <www.2stopad.org/>. ■

government news

Suicide Risk

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their ability to survive a self-inflicted injury; they are more isolated and so less likely to be rescued in time; their acts are premeditated; and they often own guns, which are in their home," said Conwell.

The primary means of suicide completion in the psychological autopsy study were firearms (48 percent), drug ingestion (16 percent), and hanging (15 percent), said Conwell.

Twenty-five percent of the elderly who committed suicide had attempted suicide before, compared with 2 percent in the control group, said Conwell.

"Other studies have shown that the ratio of attempted to completed suicides in the elderly is about 1 to 4 compared with 1 in 15 in the general population," he continued. "Our preliminary findings confirm that the elderly need aggressive, comprehensive interventions that address their social, psychological, and medical needs. Because research has shown that the elderly who committed suicide were seen recently by their primary care physicians, psychiatrists and mental health professionals should collaborate with primary care professionals to improve the detection and treatment of depression."

Some promising models of collaboration are the IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) project and PROSPECT (Prevention of Suicide in Primary Care Elderly Controlled Trial) *(Psychiatric News*, April 4), according to Conwell.

The National Center for Health Statistics of the Centers for Disease Control and Prevention has several data sets on trends in aging, including death rates, on its Web site at <www.cdc.gov/nchs/about/otheract/aging/trenddata.htm>. ■