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"See" references appear as follows:
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Eric Steckler, M.D. (left), representing APA, makes a critical point about monitoring and treating psychotropic drug side effects during a debate on psychologist prescribing sponsored by the National Academy of Sciences. Navy Cmdr. Morgan Sammons (right), a clinical psychologist, spoke on behalf of the American Psychological Association. See story on page 8.

Association News

APA Urges Court To Reject Law Allowing Youth Executions

APA joins a friend-of-the-court brief urging the Supreme Court to prohibit the execution of offenders who committed crimes when they were younger than age 18.

BY KEN HAUSMAN

The constitutionality of laws that allow states to execute offenders who committed their crimes at age 16 or 17 is the central issue in a case before the U.S. Supreme Court. Last month the APA Board of Trustees agreed to join an amicus curiae brief that argues for overturning such laws. The brief was filed with the Court on July 19.

The amicus brief, which was written by the American Society for Adolescent Psychiatry (ASAP) and contains input from APA and other organizations, argues that imaging and other data show that the brains of 16- and 17-year-olds are still developing and thus do not provide the same capability to reason, control impulses, and make certain judgments as do adult brains.

The U.S. Supreme Court has relied on similar data to declare unconstitutional the execution of mentally retarded individuals and youth under age 16—the former in its 2002 *Atkins v. Virginia* decision (*Psychiatric News*, July 19, 2002) and the latter in its 1988 ruling in *Thompson v. Oklahoma*.

In a 1989 ruling, the Court decided in *Stanford v. Kentucky* that the reasoning and the national consensus that led it to bar execution of youngsters in *Thompson* was not compelling enough to apply to 16- and 17-year-olds. Though, as Jeffrey Metzner, M.D., chair of APA's Committee on Judicial Action, noted, "There is nothing magical about age 16" that should render adolescents at this age eligible for a death penalty while those aged 15 are exempt.

In the current case, *Donald P. Roper v. Christopher Simmons*, Roper, superintendent of a Missouri prison, and other state officials are appealing a Missouri Supreme Court ruling that overturned a death sentence imposed on Simmons, who was 17 at the time he and a 15-year-old friend broke into a woman's house, robbed her, and then, after taping her eyes and mouth, threw her into a river from a railroad trestle.

Simmons had discussed with friends their intention to commit the crimes and told them he and his companion would get away with it because they were juveniles. A

please see ***Executions*** *on page 40*

Professional News

Psychologist Training Options Expand in Quest to Prescribe

It's certainly not medical school, but a significant number of psychologists have completed psychopharmacology training programs. The content of those programs vary significantly.

BY JIM ROSACK

When it comes to the question of how to educate psychologists about psychotropic medications so they can prescribe them, many have said the answer is for psychologists to go to medical school. Others, however, disagree with this stance, viewing it as a hard-line and impractical solution.

In preparation for the push by psychologists to gain legislated prescriptive authority, educators in psychology programs across the country have been setting up programs based on the curriculum developed by a panel of the American Psychological Association in 1996. The psychological association later developed and implemented a national certifying examination in psychopharmacology.

The model curriculum is aimed at doctoral-level psychologists with a current state license in good standing. The model suggests a two-part approach, involving both didactic and clinical instruction. The curriculum includes a minimum of 300 hours of instruction in courses at regionally accredited institutions of higher learning or "through continuing education courses." Course work should include neuroscience, pharmacology and psychopharmacology, physiology and pathophysiology, physical and laboratory assessments, and clinical psychotherapeutics. Training participants are also required to pass a final examination.

For the clinical practicum, the model curriculum requires "an intensive, closely supervised clinical practicum during which the psychologist should work with at least 100 patients" in both inpatient and outpatient settings that involve cases using short-term and maintenance-medication strategies. Finally, the model curriculum stipulates that "the psychologist should undergo two hours of individual supervision a week [throughout the program] by a physician or other trained personnel and must attend seminars or colloquia as needed."

Readers who think that the above is a far cry from medical school are correct. A psychiatrist puts in the equivalent of at least one academic year of coursework in the physical and biological sciences during undergraduate education and must successfully complete four years in medical school. Then comes internship and residency, amounting to another four to five years of education. In total, when most psychiatrists go into practice on their own, they usually have nine years or more of biomedical education backing up their legal right to sign a prescription.

The intensity and duration of a medical education make it superior to that of other professionals who have prescription privi-

please see ***Psychologists*** *on page 44*

WPA, Chinese Psychiatrists Agree On Psychiatry Abuse Charges

Chinese psychiatrists tell the WPA that they will remedy flaws in their country's psychiatric system that led to misdiagnosis and mistreatment of members of the group Falun Gong.

BY KEN HAUSMAN

The World Psychiatric Association (WPA) and the Chinese Society of Psychiatrists (CSP) came to an agreement in May on a response to allegations from around the world that the Chinese government used the psychiatric establishment to punish members of Falun Gong for their cultural and political beliefs.

After meeting in New York in May during APA's annual meeting, WPA President Prof. Ahmed Okasha and CSP President Prof. Donfeng Zhou issued a joint statement saying that the WPA acknowledges that the CSP has cooperated in a three-year investigation of alleged psychiatric abuses of Falun Gong members who were sent to Chinese psychiatric hospitals and clinics.

The CSP's investigation identified "instances in which some Chinese psychiatrists failed to distinguish between spiritual-cultural beliefs and delusions, as a result of which persons were misdiagnosed and mistreated."

The statement attributed these acts to "lack of training and professional skills of some psychiatrists rather than [to] systematic abuse of psychiatry."

In addition, the CSP agreed to take steps to "educate [its] members" about the issues that led to misdiagnosis and mistreatment and said it welcomes the WPA's "assistance in correcting this situation" and improving psychiatric diagnosis and treatment throughout the People's Republic of China.

Rodrigo Muñoz, M.D., is chair of APA's Council on Global Psychiatry. Regarding Chinese psychiatrists, he said, "This may not be the time to turn on them and blame them for actions" by the Chinese government.

Harold Eist, M.D., was one of the WPA negotiators who worked on the agreement concerning Falun Gong abuse charges with the Chinese Society of Psychiatrists.

While the agreement is not ideal, said Harold Eist, M.D., it represents "real progress" in preventing further abuses of psychiatry in China and will lead "to a higher quality of care."

Eist, a former APA president, was part of a delegation that hammered out this as well as an earlier agreement with the CSP in Beijing and is chair of the WPA's Standing Review Committee, which evaluates complaints aimed at psychiatric associations that are WPA members.

Eist said that the agreement is particularly significant because it is an unprecedented acknowledgment by the Chinese government that human rights abuses occurred in that country.

APA members and others involved in international psychiatry—through the WPA and other groups—began several years ago to hear reports that Falun Gong adherents were, without hearings or trials, being confined in psychiatric hospitals—usually forensic hospitals—and prison labor camps as a result of refusing to renounce their beliefs. These psychiatrists tried to bring this situation to the attention of as many people as possible.

In May 2000 the APA Committee on Abuse of Psychiatry and Psychiatrists urged the WPA to begin an investigation of charges that Chinese psychiatrists were tak-

*please see **WPA** on page 40*

APA Armed and Ready to Fight Psychologist-Prescribing Bills

BY MICHELLE RIBA, M.D., M.S

Scope of practice and related patient safety issues are top priorities for APA.

These concerns are so great that the Board of Trustees held an expanded retreat in June to consider these issues. We drew on the expertise of members across the country, staff involved in the issue on a daily basis, and, importantly, other medical specialties facing similar issues.

Armed with this good information, I have initiated a presidential task force to work with our policy councils and key staff and to advise the Board of Trustees on nonphysician scope-of-practice matters, particularly psychologist prescribing.

Other specialties agree that psychiatry is not alone in confronting assaults on safe patient care. Nonphysicians are attempting to expand their scopes of practice into several areas of medicine, including ophthalmology and anesthesiology, and it is essential that we put all that we know into this context.

Even leaders of the psychologist-prescribing effort see it this way (but for other reasons): at a recent debate (see page 8), Navy Cmdr. Morgan Sammons, who was representing the American Psychological Association, said prescribing psychologists are an "epiphenomenon"—one that coincides with changes in the health care system and the growth in number of physician assistants, nurse practitioners, and the like. His is an effort to cast psychology's attempts to gain prescribing privileges as an outgrowth of the coming of age and development of expertise of all nonphysicians as independent practitioners.

Here's some of what will inform APA's work on this issue, an effort that must grow in anticipation of the increased attempts psychology will launch in 2005:

- Many medical specialties are confronting scope of practice issues and the attendant patient safety concerns. Nonphysicians are seeking prescribing privileges not by virtue of training, but by legislative fiat.
- This is a marathon with many sprints. Specialty by specialty, state by state, year by year, bill by bill, we must advocate for our patients. Every district branch and state association must prepare for a sustained, multifront effort. It is critical to understand that nonphysicians are in this for the long haul. Psychologists worked on the issue for 20 years before they achieved success in New Mexico and Louisiana.
- Nonphysicians stand to gain, especially financially, from changing the status quo. They will try to cast physicians as defenders of the status quo, but we are not. For example, we strongly support mending the nation's broken mental health system, but we cannot agree that granting psychologists prescribing rights will improve patient care.
- State medical boards are independent of one another and often have their own politics to contend with. We must not shy away from encouraging them to join in this debate.
- State medical societies are also autonomous. They are also open to our full participation—opportunities we must take. If we do not, we cannot be certain they will participate at the level we need them to.
- Building relationships with legislators, regulators, and media is vital. Many physicians say they "don't do politics." I am reminded of the old gem, "Those who don't do politics have politics done to them." Surely, our patients lose out in this scenario.
- Psychologists are not likely to seek only prescribing rights; that's just the task before them for now. In Oklahoma, optometrists are not only authorized to prescribe, they can perform surgery on the eye with a scalpel. Could bills that create gatekeepers to the mental health system come down the pike?
- These are political struggles. If the battle for patient safety were based on the best science, the best medicine, or the best training, New Mexico and Louisiana would not have enacted their laws. We must find ways to encourage district branches and individual members to become activists for the long term with state legislators. Clearly, political action committee contributions are integral to our efforts.
- Nonphysicians are determined. We need short- and long-term strategies to ensure that we go the distance for our patients.

Many APA members have told me they feel that the psychologist-prescribing laws that two states have passed represent a great leap backwards in providing health care to Americans. I agree. Under my leadership, APA is committed to maintaining—and improving—the quality of care our patients receive.

The APA Board of Trustees, our Assembly, the Council on Advocacy and Public Policy, our medical director, the Department of Government Relations, the Division of Advocacy—indeed, the entire Association—stand ready for the 2004 elections and the 2005 legislative season.

I would very much appreciate hearing from you at mriba@umich.edu. Thank you. ■

Nominations Invited

Association News

APA members are asked to submit nominations for APA's 2005 Human Rights Award. The award, conferred yearly on an individual and/or an organization, recognizes efforts that exemplify the capacity of human beings to act courageously to prevent human rights violations, and to help victims recover from human rights abuses.

Nomination letters should describe the contributions that are the basis for the nomination and include the individual's C.V. or the organization's mission statement.

Materials should be mailed by August 28 to Council on Global Psychiatry, APA, Division of Research, 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209, or faxed to (703) 907-1087. ■

APA Educates Employers on Value Of Mentally Healthy Workforce

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

Why is it important to provide mental health resources for employees? How will it really affect our company's bottom line? These are just some of the questions that the National Partnership for Workplace Mental Health routinely addresses with employers around the country.

The National Partnership for Workplace Mental Health is a public education program of the American Psychiatric Foundation in collaboration with APA and America's employers. The workplace partnership, founded in 2001, develops and supports educational efforts for employers to generate a better understanding of the benefits of a mentally healthy workforce, early recognition of mental disorders, effective treatment, and appropriate access to quality mental health care. The workplace partnership also serves as a forum for partners to share innovative strategies for addressing mental health issues.

Among its founding partners are large companies such as AT&T, Coca-Cola, Delta Air Lines, and Dow Chemical; business organizations including the Society for Human Resource Management and the U.S. Chamber of Commerce; and government agencies such as the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration.

The workplace partnership was created because businesses purchase 50 percent of all health care in the United States and also influence federal, state, and local government purchasing. Thus, employers have the ability to leverage their buying power to improve the mental health of employees and their families.

Research shows that when companies invest in their employees' mental health, the bottom line improves through decreased physical health care costs, reduced short- and long-term disability costs, and lower absenteeism rates. The return on investment is even more dramatic when productivity gains are factored in. Healthy employees mean increased productivity and effectiveness for businesses. An economic analysis comparing depression treatment costs with lost productivity costs found that 45 percent to 98 percent of treatment costs were offset by increased productivity, according to R.C. Kessler and colleagues in "Depression in the Workplace: Effects on Short-Term Disability," published in *Health Affairs* in 1999. There is indeed a "business case for providing quality mental health care."

Since the program's inception, the workplace partnership has successfully created print and Web-based educational material and resources for employers and employees including a brochure related to disasters that has been distributed to nearly a million employees. The workplace partnership has also co-developed a highly successful quarterly newsletter, *Mental HealthWorks*, which reaches 26,000 business leaders and psychiatrists.

The workplace partnership is working with the National Business Coalition on Health to survey business coalitions across the country regarding their attitudes toward, interest in, and activities related to mental health issues. The survey results will directly inform program activities and the development of educational materials.

In addition, the workplace partnership recently joined with APA to introduce an exciting new tool to raise awareness of depression in the workplace. The Depression Calculator is an online tool at <www.depressioncalculator.com> (see page 30) that enables employers to estimate the costs and productivity savings they could reap if employees suffering from depression receive effective treatment. The workplace partnership, along with the U.S. Chamber of Commerce, the Institute of Health and Productivity Management, the Mid-America Coalition on Healthcare, and the Pharmaceutical Research and Manufacturers of America, is publicizing the availability of this tool to employers.

The workplace partnership is part of a growing stable of programs and activities in the American Psychiatric Foundation. As a charitable and educational subsidiary of APA, the foundation's mission is to advance public understanding that mental illnesses are real and can be effectively treated. The foundation is entirely supported by private contributions, which fund initiatives that are making unique and important contributions to psychiatry, such as the workplace partnership.

To receive a free subscription to *Mental HealthWorks*, send an e-mail to workplace@psych.org with "free subscription" in the subject line. In the body of the e-mail, include your mailing address, phone number, and specify whether you would like to receive the publication by mail or e-mail.

To learn more about the National Partnership for Workplace Mental Health, please visit <www.workplacementalhealth.org> or contact its director, Clare Miller, by phone at (703)-907-8673 or by e-mail at cmiller@psych.org. Information about the foundation, including details for donating, are posted at <www.psychfoundation.org>.

Feel free to share your thoughts, comments, and suggestions with me at medical director@psych.org. ■

Nominations Invited for Child Psychiatry Awards

APA invites applications for the Blanche F. Ittleson Research Award, Agnes Purcell McGavin Award for Prevention, and Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry. These awards are given to psychiatrists who have made significant contributions to child and adolescent psychiatry. They will be presented at APA's 2005 annual meeting next May in Atlanta.

The Blanche F. Ittleson Research Award recognizes published results of research in child and adolescent psychiatry. This research promises to foster important advances in promoting the mental health of children and adolescents. A psychiatrist or a group of psychiatric investigators either must have published this research within five years or have it officially accepted for publication in the near future.

The Agnes Purcell McGavin Award for Prevention recognizes a psychiatrist who has been successful in research or policy that is recognized as contributing to primary prevention of mental illness among children and adolescents. The winner will be selected from nominations by an APA member telling how the nominee's work has achieved its goal.

The Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry recognizes a psychiatrist whose career demonstrates success in research, teaching, publications, clinical care, or policy. Applications for this award should include six copies of a letter from an APA member telling how the nominee's career has contributed to American child and adolescent psychiatry and six copies of the nominee's CV.

The deadline for nominations for the Ittleson Award is August 15. The deadline for nominations for the McGavin awards is August 10.

More information about the Ittleson and McGavin awards is posted online, respectively, at <www.psych.org/dbs_state_soc/db_extranet/Awards/ittleson.cfm> and <www.psych.org/dbs_state_soc/db_extranet/Awards/mcgavin.cfm>. Information also can be obtained by contacting Jane Edgerton by phone at (703) 907-8579 or by e-mail at jedgerton@psych.org. ■

Some States Find Partial Solution to Medicaid Crisis

Amid all the red ink in states' budgets are some promising developments for beleaguered Medicaid beneficiaries.

BY KATE MULLIGAN

Michigan legislators enacted a 75-cent increase in the tax on a pack of cigarettes and directed that the revenue raised be devoted to the Medicaid program for 2004 and 2005.

Gov. Jennifer Granholm (D) had told the legislators that she would cut payments to Medicaid providers by 22 percent if they did not enact the tax, according to the June 18 *Detroit News*.

A spokesperson for the Michigan State Medical Society said that Medicaid currently reimburses doctors for only 61 percent of costs.

More than 1 in 7 state residents is enrolled in Medicaid, and the program has grown by 40 percent in the last four years, according to the *Detroit News*.

In Kentucky state officials agreed to a settlement of a lawsuit brought by Kentucky Legal Services that alleged that some people with mental illness had been unfairly excluded from in-home or nursing-home services under Medicaid because they had been ruled ineligible.

According to <www.kaisernetwork.org> on June 28, officials agreed to re-evaluate the "statuses of hundreds of people with mental disabilities who lost Medicaid coverage because of changes in eligibility requirements."

Kentucky Legal Services attorney Anne Marie Regan said, "We got pretty much everything we wanted in the lawsuit. These new standards that they agreed to use are actually more liberal than what were in place prior to April last year."

In Mississippi mental health advocates and others succeeded in delaying implementation to September 15 of the plan of Gov. Haley Barbour (R) to cut 65,000 Medicaid beneficiaries from the rolls. The cuts originally were scheduled to take place July 1.

In May the Mississippi House voted 108-0 to pass a resolution requesting that Barbour let legislators revisit the bill.

As reported on June 24, Rep. Mark Formby (R) told reporter Jason Niblett of the *Picayune Item*, "There needs to be an extension. This is the biggest mess I've seen in the 13 years I've been in the legislature."

Sen. Sid Albritton (R) said, "It's turned out to not be what they explained to us. We were told [beneficiaries] would have better care and coverage."

Angela Ladner, executive director of the Mississippi Psychiatric Society (MPS), said that it appeared that the estimated 6,000 people with chronic mental illness who were originally scheduled to be cut would be protected by a federal waiver.

She said that advocacy efforts had been

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Free Pharmacy Provides Safety Net

A quiet effort to provide low-income people with life-saving medications through a free pharmacy received statewide publicity when Mississippi Medicaid officials suggested it as a resource to the 65,000 people who were slated to lose their Medicaid benefits (see story at left).

Five years ago the Society of St. Vincent de Paul, a lay Catholic organization that helps the poor, set up the pharmacy in Biloxi for people who could not afford medications for such life-threatening illnesses as diabetes and heart disease.

The *SunHerald* reported on July 2 that pharmacy client Stacy Jacobs told reporter Kat Bergeron, "I'm bipolar, and if not for this place, I'd be up and down like a roller coaster. The medicine means I can drive and take care of my three children. I was off the medicine for a little while because I couldn't afford it, and then I heard about this pharmacy."

The pharmacy has a staff of seven pharmacists and a team of 52 volunteers who answer phones and screen applicants.

Two-thirds of the medications dispensed come from pharmaceutical samples donated by local physicians, with the remainder purchased through fundraising, donations, and grants.

In 2003 they served 758 clients, a jump of 30 percent over the previous year.

Theresa Pavlov, the pharmacy director, told Bergeron, "We are a last resort. You have to have no way to pay for your medicines, nothing left at the end of the month."

When Medicaid officials suggested the pharmacy as a source of medications, the "phone began ringing off the hook," according to the article.

Staff and volunteers were already thinking about expanding because of the growth in demand the previous year.

But, Pavlov pointed out to Bergeron, "Our mission is not to take over a state function. We can't suddenly have 1,000 new people. We are here for the people on the Coast, and our first obligation is to the people already in the program."

Gov. Haley Barbour (R) announced a delay from July 1 to September 15 of the date for implementation of the Medicaid beneficiary cuts.

APA Fights to Have Insurer Reverse Reimbursement Policy

The problem around local coverage decisions adopted by Medicare fiscal intermediaries reflects the expansion of their role beyond the processing of claims to include utilization management that sometimes intrudes on the provision of care.

BY MARK MORAN

APA is protesting rules proposed by a Medicare fiscal intermediary—Mutual of Omaha—governing reimbursement for inpatient psychiatric services.

The proposal, known as a local coverage decision (LCD), is intended to implement regulations set by the federal Centers for Medicare and Medicaid Services (CMS). Mutual of Omaha serves as a fiscal intermediary for the Medicare program in 49 states.

But APA, through its Office of Healthcare Systems and Financing, the National Association of Psychiatric Health Systems (NAPHS), and the American Hospital Association (AHA) have said that Mutual's LCD is far too restrictive, imposing requirements for an extraordinary amount of documentation far in excess of what the federal guidelines envision.

The groups also say the LCD was issued without sufficient notification to physicians who would be affected by it and without sufficient time for public comment.

In response to the protests, Mutual of Omaha has extended the deadline for comments to the middle of this month. The original deadline had been in June, according to APA's Department of Government Relations.

An action alert sent to the APA Board of Trustees, Assembly Executive Committee, and other components urged psychiatrists to send their comments on the LCD to Mutual of Omaha (see end of story for Web information).

According to the action alert, the following points should be emphasized:

- Local coverage decisions are supposed to clarify regulations. This LCD restricts Medicare benefits and imposes arbitrary and vague criteria that have little to do with medical necessity. The draft LCD will lead to blanket rejections of claims for legitimate psychiatric services.
- This LCD improperly sets standards of care for inpatient services that should be issued by regulation.
- As drafted, this LCD will have a profound impact on access to medically necessary psychiatric inpatient services.

No Time to Respond

As troubling as the substance of the LCD appears to be, APA and other groups are equally unhappy with the process by which it was formulated. CMS, in its own manuals, specifically states that fiscal intermediaries must seek input from specialty societies representing the parties affected by proposed LCDs.

"We're seeing a disturbing pattern here with the LCDs issued by fiscal intermediaries," said Nicholas Meyers, director of government relations at APA. "They have simply posted the rules on their Web sites and made absolutely no effort to reach out to affected stakeholders. This creates a significant barrier to the comment process. We believe the 'stealth' notice violates the intent of public notice and comment requirements for such rules, and it's certainly out of line with recent action by Congress to prod Medicare contractors to work cooperatively with physicians. There's no justification for it."

Meyers praised the response from APA members. "Our individual members responded magnificently under a very tight deadline. Their efforts really helped. As a result, to its credit, Mutual extended the comment period, which will allow APA, our allies, and our members to offer detailed comments on the rule."

Intermediaries Do Utilization Management

Mutual is not the first Medicare fiscal intermediary to write local coverage decisions for inpatient psychiatric services. Administar, a fiscal intermediary in Illinois, and Associated Hospital Service, in Massachusetts, also drafted LCDs that were proscriptive and issued with no direct notification of physicians who would be affected by them.

In both cases, protests by APA and other groups were successful in getting the comment period extended and persuading the fiscal intermediaries to reconsider much of the content. And the LCD drafted by Mutual of Omaha appears to be all but identical to those drafted by the other fiscal intermediaries.

Psychiatrist Anil Godbole, M.D., told *Psychiatric News* that the problem reflects the expanded role of fiscal intermediaries in the Medicare program. Originally serving primarily to process claims, fiscal intermediaries have now taken on the task of utilization management and review, he said.

In the same manner as managed care companies in the private sector, the rules written by the fiscal intermediaries to implement federal guidelines for reimbursement of services are so proscriptive as to intrude on the actual practice of medicine and provision of care, Godbole said.

As a member of the advisory panel to Administar, Godbole was alerted in October last year to a local medical review pol-

please see ***Insurer*** *on page 39*

Senate Votes Grant Program For Youth Suicide Prevention

A mental health coalition of which APA is a member praises the Senate's passage of a bill that would provide federal funding for suicide-prevention services, particularly those directed at youth.

BY CHRISTINE LEHMANN

To address the fact that suicide is a leading cause of death among adolescents and college students, the U.S. Senate passed legislation last month that would provide $10 million for competitive grants to colleges and universities for student mental health services.

About half of the college students who seek help from campus counseling centers report feeling hopeless or severely depressed, according to the American College Health Association.

When college counseling center directors were surveyed last year, 81 percent reported being concerned about the increasing number of students with severe psychological problems. Sixty-seven percent of these directors said they needed to increase psychiatric services at their college, according to a 2003 Gallagher's Survey. Robert Gallagher, a psychologist at the University of Pittsburgh, conducts an annual national survey of counseling centers.

The Senate-approved Garrett Lee Smith Memorial Act (S 2634) would also authorize federal grants for state suicide-prevention programs aimed at youth. The legislation is named for the son of Sen. Gordon Smith (R-Ore.). Garrett, who was 21, committed suicide last year after battling bipolar disorder.

The Campaign for Mental Health Reform, a national coalition of organizations representing people with mental illnesses, their families, mental health advocates, and professionals, said that it applauds Sen. Christopher Dodd (D-Conn.) and the bill's 30 other cosponsors "for making youth suicide prevention an important priority by unanimously passing the Garrett Lee Smith Memorial Act."

On the Senate floor before the vote, Smith said, "Garrett suffered emotional pain that I cannot begin to comprehend. He ultimately sought relief by taking his own life," according to the July 8 Capitol Hill publication *CQ Today*.

"Too many families in this country have faced tragedies that could have been avoided with the proper help, support, and counseling," said Sen. Jack Reed (D-R.I.), who cosponsored the legislation with Dodd and Sen. Mike DeWine (R-Ohio).

Reed spoke at a recent hearing of a subcommittee of the Senate Health, Education, Labor, and Pensions (HELP) Committee. "We need to identify the students who are feeling depressed, stressed, and pressured and help them avoid making a devastating mistake," Reed said.

Universities and colleges could use the grants for suicide-oriented prevention screenings, early intervention, assessment, treatment, and management, the legislation says. Funds also could be used to educate students and parents about mental and behavioral health problems, hire staff, and expand training of health care staff.

The average ratio of counselors to students at institutions of higher education with more than 15,000 students is 1 per 2,400 students, according to the International Association of Counseling Services, which recommends one counselor for every 1,000 to 1,500 students.

The 2003 Gallagher's Survey also found that 63 percent of the directors of college counseling centers were experiencing difficulty meeting the growing demand for counseling services without additional resources.

The Garrett Lee Smith Memorial Act was referred on July 9 to the House of Representatives Committee on Energy and Commerce.

The legislation can be accessed online at <thomas.loc.gov> by searching on the bill number, S 2634. ■

Medicaid

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enhanced by the fact that MPS shares offices with state chapters of the National Alliance for the Mentally Ill and the National Mental Health Association.

"From day one, we've been on the same page and have presented a unified front on behalf of people with mental illness."

Results of a poll reported in the *Delta Democrat Times* of Greenville, Miss., indicated that only 1 percent of the state's residents favored cuts to the Medicaid program as a means to balance the budget.

On June 14 *New York Times* columnist Bob Herbert editorialized against the cuts.

Herbert wrote that in signing the law, Barbour had said that Mississippi taxpayers have to "pay for free health care for people who can work and take care of themselves and just choose not to."

Herbert continued by writing that the governor is "free to characterize the victims of the cuts as deadbeats if he wants to," but that some have "incomes so low they effectively have no money to pay for health care."

Herbert also noted that Barbour's idea that many of those cut from the rolls could get prescription drug benefits and other health care through Medicare is flawed because "in most cases [it] will not come close to meeting their overall requirements" (see box on page 5). ■

The 'Two APAs' Debate Psychologist Prescribing

A psychologist says prescribing privileges are a remedy for a broken health system, while a psychiatrist says that patient safety is at stake.

BY JIM ROSACK

In keeping with its mission to "bring together experts in all areas of science and technology to address critical national issues," the National Academy of Sciences last month sponsored the debate "A Bitter Pill: Should Psychologists Have Prescriptive Privileges?"

The debate featured Eric Steckler, M.D., president of the Northern Virginia chapter of the Washington Psychiatric Society on behalf of APA, and Cmdr. Morgan Sammons, deputy director for clinical operations at the U.S. Navy Bureau of Medicine and Surgery. Sammons is a doctoral-level psychologist on active duty in the Naval Medical Corps. He noted he was speaking on behalf of the American Psychological Association as a private citizen, not in his capacity as a naval officer.

Speaking first, Sammons, a graduate of the first class of the Department of Defense's Psychopharmacology Demonstration Project—a pilot project begun in 1988 to train psychologists to prescribe—characterized the issue as "part of an enormous transformation of our health care system."

The move to grant psychologists prescriptive authority, Sammons said, "takes place in the context of a vast transformation in American health care, an extraordinary rate of change in the scope of practice of any nonphysician provider."

Sammons went on to note that "our mental health system, as Dr. Steckler will talk about in a few moments, is so badly broken. We believe that prescriptive authority will help to rectify this really tragic situation for many Americans."

Sammons suggested that prescribing psychologists would be better equipped to offer integrated and comprehensive care combining the best psychological interventions with pharmacotherapy. Sammons added that he believes psychiatrists are mourning the loss of their ability to provide psychotherapeutic interventions in today's managed care environment of mandated med checks.

Sammons detailed the highlights of the American Psychological Association's model curriculum for training psychologists to prescribe and the requirements of the New Mexico and Louisiana statutes. Sammons is on the faculty of at least three institutions offering psychopharmacology training programs designed to meet these requirements (see related article on page 1).

At one point in his remarks, Sammons suggested that prescribing psychologists would give superior care to patients compared with primary care physicians, noting that primary care physicians write the majority of prescriptions today for antidepressants, while providing little or no psychosocial intervention.

"It used to be just antidepressants," Sammons argued, "but now many pharmaceutical firms market their antipsychotics to primary care physicians, and I think at least one area where we can reach some common ground is that we don't believe that this is the most effective use of these medications for complex and severe, persistent mental disorders."

Sammons finished his allotted time by declaring that "the patient-safety argument just isn't an issue." He emphasized, "If any nonphysician health care provider with prescriptive authority was harming patients, you can bet they would be stopped immediately."

Steckler, a child and adolescent psychiatrist in private practice in McLean, Va., met Sammons head on by first noting that he doesn't know any psychiatrists in mourning for psychotherapy.

"I do therapy in my office every day," Steckler said, "and just about everyone I know does." He agreed with Sammons that the system is, indeed, badly broken. But the solution is not to grant a legal right to prescribe to individuals "ill prepared to accept the responsibility."

Steckler detailed the very different pathways leading to prescribing privileges for physicians compared with those contained in the two state laws allowing psychologists to prescribe.

"A psychiatrist has nine years of biomedical education under his or her belt," Steckler emphasized. "A psychologist may have a great deal of psychosocial and behavioral education, but would need only one year of biomedical education to meet the requirements in New Mexico or Louisiana."

Psychologists, Steckler added, have provided great contributions and advances to the treatment of mental illness, including effective psychosocial interventions and tools that greatly aid the diagnosis and ongoing assessment of patients. But giving psychologists prescriptive authority is not the answer to increasing access to mental health care, Steckler said.

"Psychologists are no more likely to practice in underserved areas than psychiatrists," he said. "We all practice in the same areas now, just down the street from each other. That isn't going to change."

Granting prescribing privileges to psychologists will lead only to a decrease in the quality of care and raise significant patient safety issues, he said.

Steckler's arguments became more pointed during the question-and-answer period following the two speakers' presentations.

In response to a question from the audience asking Sammons whether he could

please see ***Debate*** *on page 13*

Should Sleep-Starved Residents Be Setting Off Alarms?

Residents at U.S. hospitals stumble through PGY-1 and PGY-2 in "a nearly continuous state of chronic partial sleep deprivation."

BY LYNNE LAMBERG

Resident physicians in all specialties averaged 5.7 hours of sleep a night in PGY-1, and only 13.8 minutes more a night in PGY-2, a nationwide survey shows.

Among more than 1,600 PGY-1 residents in 21 specialties, those in pathology got the most sleep, an average of 6.9 hours a night. General surgery residents got the least, only five hours. PGY-1 psychiatry residents ranked fourth highest, averaging six hours a night.

While individuals differ in their physiologic need for sleep, sleep specialists say most adults need about eight hours for optimal performance.

Dewitt Baldwin, M.D., a scholar in residence for the Accreditation Council for Graduate Medical Education (ACGME), and Steven Daugherty, Ph.D., an assistant professor of psychology at Rush Medical College in Chicago, conducted the survey. Using the AMA's graduate medical education database, they queried a randomly selected sample (15 percent) of all PGY-1 and PGY-2 residents in the United States in the 1998-99 training year. Of 5,616 eligible residents, 3,604 participated, a 64 percent response rate.

Survey participants completed a five-page questionnaire with 44 questions that required 144 separate responses regarding work hours, supervision, learning, stress, and other aspects of residency training, as well as sleep. The researchers preserved residents' anonymity.

Baldwin and Daugherty published the survey findings in *Sleep* in March. They reported additional correlations between sleep and work hours at the annual meeting of the Associated Professional Sleep Societies in Philadelphia in June.

On nights on call—superimposed on weekly averages—residents often sleep only two or three hours, the researchers found. Among all residents, only 15 (0.4 percent) said they averaged eight or more hours of sleep a night.

Residents who sleep less and work longer than most of their peers express the greatest dissatisfaction with their residency experience. That suggests, Baldwin and Daugherty said, "that sleep deprivation also interferes with learning, the primary purpose of residency training."

Most residents said their work hours were too long.

PGY-1 residents said they averaged 83 hours of work a week, while PGY-2 residents said they averaged 76 hours of work a week. Nearly half of PGY-1 and one-third of PGY-2 residents said they worked more than 80 hours a week, Baldwin and Daugherty reported in *Academic Medicine* in November 2003.

While 72 percent of psychiatry residents averaged 60 hours of work a week, 7 percent of psychiatry residents—mainly those in high-intensity academic programs—claimed they worked an average of 106 hours a week. ACGME regulations that went into effect July 1, 2003, limit residents to 80 hours of work a week.

Few PGY-1 residents in any specialty moonlighted. About 17 percent of PGY-2 psychiatry residents did, however, averaging 29.5 hours a month at second jobs. "That shows they had the opportunity to choose to sleep, study, or spend free time with their families or on other activities," Baldwin said in an interview.

Residents who slept five or fewer hours a night were more than twice as likely as those who slept longer to report having worked five or more times in an impaired condition. Residents who got less sleep were nearly twice as likely to report they had made a significant medical error, been named in a malpractice suit, had a serious accident or injury, or had a serious conflict with other residents, attendings, or nursing staff.

While the 80-hour rule hypothetically enables residents to get more sleep, "it is not clear that this will be the case," the researchers asserted. Residents make different choices about how to spend unscheduled time. Although work and sleep hours showed an inverse relationship, work hours accounted for only 10 percent of the variance in reported sleep hours.

Charles A. Czeisler, M.D., Ph.D., the Frank Baldino Jr., Ph.D., Professor of Sleep Medicine at Harvard Medical School, expects reducing work hours to increase sleep time. "The highest number of weekly work hours in the PGY-1 year resulted in 19 percent fewer hours of weekly free time, but was associated with only 4 percent fewer hours of sleep," he noted in an editorial in *Sleep* in May.

"Sleep is a biological imperative," Czeisler stressed in an interview. "It is not a matter of choice." As work hours increase, he asserted, sleep is preserved as a greater fraction of free time. Nonetheless, since there are 168 hours in a week, people who work more than 100 hours a week can't possibly sleep eight hours a night.

Long-term effects of chronic sleep restriction are unknown, Czeisler said. Ethical considerations likely would prevent simulation of residents' schedules in the laboratory.

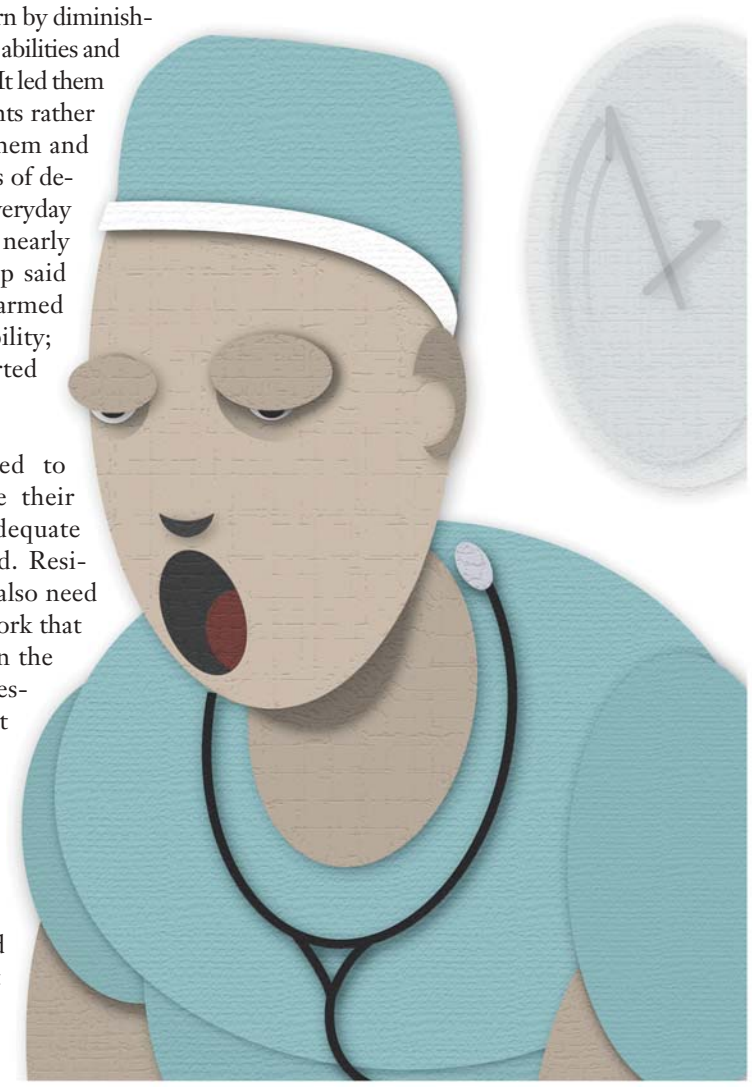
If validated measures confirm the higher risks of medical errors and accidents that the self-report survey findings indicate, Czeisler added, "the medical profession will be obligated to address the risks to both patients and residents associated with chronic sleep restriction."

Czeisler and colleagues are conducting an intensive study of sleep and work schedules in 20 PGY-1 residents a year at the Brigham and Women's Hospital in Boston. The residents keep daily work and sleep logs and complete questionnaires; their sleep is recorded polysomnographically. Observers also monitor their work performance. The second year of the study ended in June, and Czeisler said he expects to report findings late this year.

Resident physicians know no more about the benefits of good sleep than does the general public, says Kingman Strohl, M.D., a professor of medicine and director of the center for sleep disorders research at Case Western Reserve University and the Louis Stokes Cleveland Veterans Affairs Medical Center.

Some residents assert that physicians handle sleep loss better than other people or insist they can learn to cope with sleep loss. Said Strohl, "I don't believe there is any evidence to support such claims."

Strohl and colleagues recruited 149 residents in six specialties at five U.S. academic health centers to participate in small focus groups and answer questionnaires about effects of sleep loss and fatigue. As the researchers reported in *Academic Medicine* in May, residents said lack of sleep impaired their ability to learn by diminishing their cognitive abilities and complex thinking. It led them to objectify patients rather than "care" for them and prompted feelings of detachment from everyday life. Residents in nearly every focus group said sleep loss had harmed their driving ability; some reported drowsy-driving crashes.



Residents need to learn to manage their time to assure adequate sleep, Strohl said. Residency programs also need to reduce busy work that keeps residents in the hospital. It's necessary to educate not only residents but also program directors and hospital administrators, he said, about the importance of sleep and functional impact of sleep loss.

"If I were running a residency program," Baldwin added, "I'd cut scut work and never hold lectures in the early afternoon, when sleepiness is overpowering. I'd also have a room where residents could nap. As little as 20 minutes of sleep can rejuvenate a person for several hours."

The American Academy of Sleep Medicine offers an online instructional module on sleep for residency training programs at <http://aasmnet.org/safer.htm>. An abstract of "A National Survey of Residents' Self-Reported Work Hours: Thinking Beyond Specialty" is posted online at <www.academicmedicine.org/cgi/content/abstract/78/11/1154?>. ■

SAMHSA Tries Several Strategies To Reach One Goal—Ending Stigma

Eight states are participating in a new awareness campaign designed to reduce the stigma surrounding mental illness.

Mental illnesses are common, leaving very few families in the United States untouched, but recovery is within reach.

That's the message broadcast by the new public education campaign, "Mental Health: It's Part of All Our Lives," which the Substance Abuse and Mental Health Services Administration (SAMHSA) launched in May.

The campaign is part of SAMHSA's three-year Elimination of Barriers Initiative, which aims to increase understanding and acceptance of people with mental illness.

The initiative is a collaborative effort between SAMHSA and a number of state mental health authorities in partnership with people with mental illness, their families, mental health advocates, and health care providers.

The eight states participating in the campaign are California, Florida, Massachusetts, North Carolina, Ohio, Pennsylvania, Texas, and Wisconsin.

In North Carolina, for example, high school teachers, administrators, and principals are being trained to deal effectively with mental health problems among students in 10 schools.

Last May in Boston, more than 3,500 people participated in a 5-kilometer walk sponsored by the National Alliance for the Mentally Ill to raise awareness about and reduce stigma surrounding mental illness.

"The fear and stigma that surround mental health problems make it harder for people to access treatment, find employment, or obtain housing," SAMHSA Administrator Charles Curie said in a press release. "Fortunately, everyone can do something to help reduce stigma."

Based on data from SAMHSA's National Survey on Drug Use and Health, researchers estimated that 17.5 million adults in the United States had a serious mental illness in 2002.

More information about "Mental Health: It's Part of All Our Lives" is posted online at <allmentalhealth.samhsa.gov/english/>. ■

Neuropsychiatry Institute Receives Huge Grant for Brain Studies

The benefactors hope that their donation will help build a stronger bridge between academic research and community outreach.

Terry S. Semel and Jane Bovington Semel have donated $25 million to endow the Neuropsychiatric Institute at the University of California at Los Angeles (UCLA). The gift is one of the nation's largest dedicated exclusively to the better understanding of the brain, according to Peter Whybrow, M.D., the institute's director.

Semel, who is the chair and chief executive officer of Yahoo Inc., and his wife will lay the cornerstone of an academic-community partnership facilitating a better public understanding of the brain and of complex human behavior through science, education and compassion, according to Whybrow. The Semel gift will support research and community education programs to address the understanding and treatment of such diverse illnesses as autism, mood disorders, addiction, and Alzheimer's disease.

In recognition of the Semels' generosity, the institute will be renamed the Jane and Terry Semel Institute of Neuroscience and Human Behavior at UCLA. Jane Semel will chair the institute's Board of Community Counselors.

Prior to joining Yahoo, Semel spent 24 years at Warner Bros., notably as chair and co-chief executive officer. Jane Semel is founder of ijane inc., a nonprofit production company that works to address public health issues through entertainment. She launched FaceTheIssue.com, an integrated broadcast and online public service campaign that aimed to raise awareness of common emotional and physical health issues faced by young adults. The campaign was narrated by Hollywood's top female entertainers, including Halle Berry, Nicole Kidman, Julianne Moore, and Catherine Zeta-Jones.

Since its founding five decades ago, the Neuropsychiatric Institute has gained a worldwide reputation for the high quality of its clinical services and comprehensive research program.

More information about the Semels' donation is posted at <http://newsroom.ucla.edu/page.asp?RelNum=5302>. ■

AMA Delegates Vote to Return To Honolulu

BY MARK MORAN

If psychiatrist Jeffrey Akaka, M.D., approaches you, don't be surprised if you get a pack of macadamia nuts and an invitation to the Aloha State.

Akaka, an APA delegate and member of the Section Council on Psychiatry to the AMA House of Delegates and a Hawaii native, has been tireless in urging the AMA house to return to Honolulu periodically for its interim meeting in December.

Jeffrey Akaka, M.D.

In turn, Akaka and his colleagues in the Hawaii Medical Association and Hawaii Psychiatric Medical Association have translated the goodwill—and significant tourist revenues—the meeting has generated into political capital with Hawaii's legislators in ongoing battles over psychologist prescribing in that state.

During the House of Delegates meeting in Chicago in June *(Psychiatric News*, July 16), delegates overwhelmingly approved a resolution to return to Honolulu in 2007 or 2008 for the interim meeting. The resolution was sponsored by APA, along with the American Academy of Psychiatry and the Law and the Hawaii, Alaska, California, and Kansas state delegations.

The resolution was not without opposition from some delegates, who said the cost of the meeting to the AMA, along with the clinical time lost in travel, made return to Honolulu unsupportable. Other delegates said that the Hawaii meeting has sometimes been perceived by other AMA members as a junket.

But just as many delegates testified to work that has been accomplished by the House of Delegates in a meeting devoted to advocacy and legislative issues. The tide turned when representatives from the Hawaii Medical Association reported that a pledge of financial and logistical support to defray costs of the Honolulu meeting had been obtained from the convention bureau there.

Akaka told delegates that the meeting was reaping political rewards with the state's leadership. At the 2003 interim meeting in Honolulu, he said, the Hawaii Medical Association facilitated a scope-of-practice panel involving the chair of the Hawaii Senate's Education Committee, a Democrat, and the state House of Representatives' minority leader, a Republican.

"From the 2003 interim meeting through now, and throughout the entire subsequent legislative session, not a single crash-course psychology prescribing bill has been introduced in either the House or the Senate of the state of Hawaii," he told AMA delegates.

Akaka's work in bringing leaders of psychiatry and medicine together with political leadership in his state is regarded by some of his colleagues as a political masterstroke. ■

Combat Involvement Raises Risk Of Developing Mental Illness

Military researchers are taking a proactive approach to identifying mental health problems in soldiers in combat operations.

BY CHRISTINE LEHMANN

American soldiers and Marines engaged in ground combat operations in Iraq last year developed more mental health problems than soldiers on the ground in Afghanistan in 2002.

The study, published in the July *New England Journal of Medicine*, is the first to examine the mental health status of soldiers returning from combat operations in Iraq and Afghanistan.

The military researchers surveyed about 6,000 U.S. Army soldiers and Marines anonymously last year. Lead author Charles Hoge, M.D., told *Psychiatric News*, "We surveyed three Army and Marine units three months after they returned from Iraq and Afghanistan and one large Army unit one week before deployment to Iraq in January."

Hoge is chief of psychiatry and behavioral sciences at Walter Reed Army Institute of Research in Washington, D.C. "This is a longitudinal study in which we track soldiers through assigning numbers since we can't use their names," said Hoge.

The Army researchers are taking a proactive approach to identifying mental health problems in returning soldiers from Iraq in particular. "We learned only years after soldiers returned from Vietnam that many of them had posttraumatic stress disorder [PTSD], which delayed treatment," said Hoge and his colleagues at Walter Reed.

They used standardized checklists to screen the soldiers for the presence of PTSD, major depression, and generalized anxiety. Two screening definitions were used for each disorder.

Both definitions used the *DSM-IV* symptom criteria, but the broad definition excluded criteria for functional impairment, while the strict definition "required a self-report of substantial functional impairment or a large number of symptoms," according to Hoge and his colleagues.

The percentage of soldiers who met the strict screening definition for major depression, generalized anxiety, or PTSD was significantly higher after duty in Iraq (17 percent) than after duty in Afghanistan (11 percent) or before duty in Iraq (9 percent), the researchers reported.

The researchers found that combat exposure was related to the presence of psychiatric disorders. The highest rates of disorders were among the 1,700 Army infantry soldiers and Marines whose tour of duty started with the U.S.-led invasion of Iraq on March 20 and ended six to eight months later.

This group of soldiers reported engaging in heavy combat during the invasion, more frequent combat, and more frequent contact with the enemy than soldiers who returned from Afghanistan.

Rates of PTSD were significantly higher after combat duty in Iraq than before deployment. PTSD was highest in soldiers who had been shot at, handled dead bodies, killed enemy combatants, or knew someone who had been killed, Hoge and his colleagues reported.

When mental health care was offered to the respondents with functional impairment or the greatest number of symptoms, only about 40 percent were interested in seeking help, and only about 30 percent reported receiving help in the preceding year, the researchers stated.

Stigma and concerns about confidentiality were the main barriers to seeking mental health care, the authors reported.

Hoge commented that military clinicians have an obligation to maintain patient confidentiality but, unlike their civilian counterparts, are also responsible for assessing a soldiers' fitness for duty. "If a soldier is severely impaired and can't safely operate highly technical weapons or equipment, that is a compelling reason to notify his commander," said Hoge.

He emphasized that most soldiers who receive mental health care function well with medication and support.

Hoge and his research team briefed military leaders last year on the results and recommendations of the study. The recommendation to provide confidential counseling sessions through employee-assistance programs was implemented last fall, Hoge said.

The researchers also recommended that screening for PTSD be implemented in military primary care settings, where soldiers are usually screened for depression. ■

Debate

continued from page 8

describe a patient that he would be uncomfortable treating, he replied that he would not treat a patient who presented with serotonin syndrome in his office; he would refer the person. The questioner then asked Steckler how he would deal with a patient with serotonin syndrome.

"I'd continue to treat [the patient]," Steckler replied, adding he would watch the patient and make any necessary adjustments in medication.

Sammons interjected, "What if [the patient had] a severe or complicated [case of] serotonin syndrome?," appearing surprised that Steckler would adopt such a "watch and wait" stance.

"My patients wouldn't be in that position in the first place," Steckler concluded. ■

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Poor Endure Access Problems In All Regions of U.S.

Access to specialty care, including mental health services, is a serious problem for those who rely on the health care "safety net."

BY KATE MULLIGAN

Serious problems with access to mental health services have surfaced in one of the periodic analyses by the Center for Studying Health System Change (HSC) about the viability of the "safety net."

Every two years HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The communities are Boston, Cleveland, Greenville, S.C., Indianapolis, Lansing, Mich., Little Rock, Ark., Miami, northern New Jersey, Orange County, Calif., Phoenix, Seattle, and Syracuse, N.Y.

The researchers interview individuals who are involved directly or indirectly in providing safety-net services to low-income people.

The issue brief, "Health Care Access for Low-Income People: Significant Safety Net Gaps Remain," published in June, reports on interviews that occurred in 2002-03.

Comments such as "the mental health delivery system is in shambles" expressed the extent of these problems, according to researchers Laurie E. Felland, Suzanne Feit-Lisk, and Megan McHugh.

Access to mental health services surfaced as a significant problem in eight of the 12 communities, although Felland told *Psychiatric News* that it should not be assumed that access was not a challenge in all the communities.

"Safety net providers are not equipped to meet the wide range of health care needs of all low-income people. . . ."

"We are hearing that more and more patients are showing up at community health clinics and other places that provide primary care with serious mental health problems that have not been treated," she said.

HSC researchers typically have not interviewed individuals directly involved in providing mental health services, so these reports of problems suggest that mental health access issues are being manifested in the primary health care system.

Felland said that their respondents also reported that more people with psychiatric emergencies are showing up in emergency rooms, a trend that has been documented in other research *(Psychiatric News*, June 18).

One positive development has been the addition of mental health and substance abuse treatment services to community health centers through the use of federal grants from a program begun in 2002 by President Bush to expand and improve services at those centers.

Felland and colleagues wrote, "State and local policymakers are aware of the access problems for specialty, mental health, and dental services, but communities have been more active in addressing the issue."

They continued by noting that budget constraints have hampered states' ability to allocate funds over the last few years.

Felland said that although some states had increased Medicaid provider rates, those rates often were still much lower than private insurer rates.

In addition, the HSC analysis was based on 2002-03 interviews before the deepest cuts to Medicaid had begun.

The researchers concluded, "Across communities, low-income and uninsured people face long-standing, and sometimes worsening, difficulties in obtaining specialty, dental, and mental health services. . . . Safety net providers are not equipped to meet the wide range of health care needs of all low-income people, and access to private practitioners remains limited."

They identify low payment rates as a major barrier to access.

"Health Care Access for Low-Income People: Significant Safety Net Gaps Remain" is posted online at <www.hschange.com/CONTENT/682/>. ■

Association News

Minority Medical Students Invited To Apply for IPS Scholarship

APA invites minority medical students to apply for its 2004 Institute on Psychiatric Services Meeting Travel Scholarship.

The scholarship is designed to bring minority medical students interested in public psychiatry, clinical issues, and the challenges of service delivery to APA's institute, where they will participate in a wide variety of resident and fellow activities at the meeting. It will provide participants with an unparalleled opportunity to meet and network with faculty, psychiatry residents, and each other. It is open to currently enrolled U.S. minority medical students. Selected students who are not APA members will automatically receive membership.

The scholarship supports travel and related costs for approximately 10 medical students to attend the institute, to be held October 6 to 10 in Atlanta.

This scholarship is a part of the APA Minority Fellowships Program and is supported by the Substance Abuse and Mental Health Services Administration.

Applicants must submit an application form (available online), a brief statement of interest not to exceed one typewritten page, a letter from the dean's office indicating that the applicant is a student in good standing, and the applicant's curriculum vitae.

Applications are due by August 30.

Applications and more information are available by contacting Marilyn King by phone at (703) 907-8653 or by e-mail at mking@psych.org; or visiting the Web <www.psych.org/edu/other_res/apa_fellowship/medstudtravel_IPS2004.pdf>. ■

Vacation Plans Should Include Lots of Prep Work

Headed to the mountains or beach this summer? Before packing those suitcases, psychiatrists can take certain steps to ensure that their patients are well cared for during vacation breaks.

BY EVE BENDER

Whether sitting seaside or backpacking through the mountains, the long-awaited vacation is the time psychiatrists use to rest, relax, and re-energize.

However, being away from the office can also increase psychiatrists' liability risk if they don't take steps ahead of time to ensure that patients are receiving good care during their absence.

Marynell Hinton, M.A., a senior risk manager with Professional Risk Management Services Inc. (PRMS), recently shared some risk management advice with *Psychiatric News* for psychiatrists about to leave for vacation.

PRMS is the company that manages the APA-endorsed liability insurance program, known as the Psychiatrists' Professional Liability Insurance Program.

Maintain Patient Privacy

Keeping a patient's medical information private is always a top priority for psychiatrists, but confidential information may be more vulnerable when the treating psychiatrist is out of the office.

During these times, psychiatrists can take extra steps to preserve patients' privacy by instructing office staff not to release confidential information to any person without advance approval.

Hinton advised psychiatrists to be attentive to potential breaches of confidentiality when using mobile phones, computers, fax machines, or voice mail because "you may be overheard or the message may be intercepted by the wrong party."

Document All Correspondence

Documentation, the cornerstone of good risk management practices, is necessary even when psychiatrists are away.

Before leaving for vacation, psychiatrists should update patient charts for the benefit of the psychiatrists covering for them.

While away, psychiatrists should document all calls to and from patients and to and from third parties—such as a pharmacist or covering physician—concerning patients. Hinton recommended that psychiatrists use a form the size of an index card with an adhesive backing that easily fits into a pocket or purse to document calls received outside of the office.

Upon the physician's return, the cards can be affixed to the patient's medical records.

Leave Instructions

Of course, it's essential to prepare patients for scheduled absences and make provisions for coverage, Hinton said. "Be specific about the length of time of the absence and the dates of your departure and return," she added.

It is also a good idea for psychiatrists to provide patients with written information, such as a list of names and telephone numbers to call and dates of absence, to which patients can refer while the psychiatrist is away.

Although it's standard practice in many offices, psychiatrists should leave specific instructions on voice mail with office staff, and with answering services as to how patients should be directed to services in the psychiatrist's absence.

"Make sure the information includes instructions about where patients can access care in an emergency, including going to the patient's local emergency room," Hinton stressed.

Alert Staff to At-Risk Patients

It's essential for psychiatrists to provide colleagues who are covering for them with pertinent information about "at-risk" patients, such as those who have suicidal or homicidal ideation.

This may include information about what has helped the patient during past crises, the patient's current stressors, and whom to contact if the patient is in crises, Hinton said.

It is also important for psychiatrists to leave a number with colleagues where they can be reached if they need to be consulted in an emergency.

Vacationing psychiatrists should instruct staff on how to deal with potentially or increasingly suicidal patients and how to notify the psychiatrist after they take action involving the patient, Hinton said.

She also advised psychiatrists to "be wary of treating patients by telephone without a follow-up office visit as soon as possible."

Monitor Prescription Needs

Hinton also offered risk management advice about prescriptions: "Try to anticipate medication refills and determine which of those will require ongoing monitoring during absences," she said. She warned psychiatrists to lock up prescription pads while they are out of the office for any length of time.

After returning to the office, psychiatrists should save documentation such as airplane tickets, hotel bills, and coverage instructions. "These will come in handy should you be accused of malpractice during a time when you were, in fact, out of town," she pointed out.

Learn About Patients Beforehand

Psychiatrists who fill in for their vacationing colleagues can also benefit from risk management tips that will protect them from increased liability risk.

"It's a good idea to spend some time with your colleague to learn more about those patients who might require continued assistance during the psychiatrist's absence," Hinton said. Also, before the colleague leaves, covering psychiatrists should find out how to gain access to patients' pertinent medical information while the treating psychiatrist is away.

It's also useful for covering psychiatrists to know which hospitals their colleague admits patients to and then determine if they also have admitting privileges at those hospitals.

Whenever possible, the covering psychiatrist should admit patients to a hospital where he or she and the colleague both have admitting privileges so the patient receives uninterrupted care.

At the very least, the covering psychiatrist should admit the patient in crisis to a hospital where the treating psychiatrist can resume care when he or she returns from vacation, Hinton said.

When covering for a colleague who has a practice that includes managed care patients, psychiatrists may want to consider whether they will be paid for covering these patients.

Hinton said some psychiatrists may be able to bill on an out-of-network basis, and some managed care networks may have a provision for covering doctors that aren't designated as panel members.

Finally, if the colleague will be away for more than two weeks, the covering psychiatrist should know who in the office is designated to handle nonmedical legal and business matters.

More information on PRMS and the Psychiatrists' Professional Liability Insurance Program is posted online at <www.prms.com>. ■

Practical Pointers

For Vacationing Psychiatrists

- Prepare patients for scheduled absences and make provisions for other psychiatrists to cover.
- Instruct staff not to release confidential information to anyone without your advance approval.
- Be wary of treating patients by telephone without a follow-up office visit as soon as possible.
- Provide colleagues who are covering for you with specific information about at-risk patients.
- Anticipate patients' need for medication refills.
- Lock up prescription pads.
- Save travel documentation such as airplane tickets and hotel bills.

For Covering Psychiatrists

- Learn before your colleague goes away about patients who might require extra assistance during their psychiatrist's absence.
- Find out beforehand how to access pertinent medical information about patients.
- Know the dates you will be covering for your colleague and know to which hospitals he or she admits patients.

Candidates Sought for Evaluation On Oral Examination

APA is accepting candidates for a pilot program to provide diagnostic evaluation of performance on an oral examination similar to Part 2 of the boards. Only candidates who have failed the oral board (Part 2 of the ABPN exam) two or more times are eligible to participate.

Candidates will be evaluated by current and past board examiners on their performance on a live patient interview and clinical vignettes. Candidates will then be given feedback on factors that interfere with their performance. Remediation will be the responsibility of the participants. Tuition for this diagnostic assessment is $500.

The pilot program can accommodate only 24 candidates. Participants will be chosen by lottery from the applications received by the deadline, which is November 1.

The program will held at SUNY Downstate Medical Center at 450 Clarkson Avenue in Brooklyn, N.Y., on December 4.

Those interested in applying should contact Nancy Delanoche by e-mail at ndelanoche@psych.org or by phone at (703) 907-8635. More information, including an application form, can be obtained from APA's Web site at <www.psych.org/edu>. ■

Olmstead's Good Intentions Slow to Be Realized

Many states are still at the planning stage of implementing the *Olmstead* decision. Those emerging plans are often vague and divorced from funding realities.

BY KATE MULLIGAN

At a meeting marking the fifth anniversary of the *Olmstead* decision by the U.S. Supreme Court, participants reported limited progress in implementation (see box below).

The meeting, titled "The *Olmstead* Decision Five Years Later: How Has It Affected Health Services and the Civil Rights of Individuals With Disabilities?," was hosted in late June by the Alliance for Health Reform and the Kaiser Commission on Medicaid and the Uninsured.

Five years earlier, on June 22, 1999, the U.S. Supreme Court ruled in *Olmstead v. L.C.* that states are required to place persons with mental disabilities in community settings when the treatment professionals deem that setting appropriate, the individual does not object, and the placement can be "reasonably accommodated" *(Psychiatric News*, July 16, 1999).

Michael Gottesman, who argued the plaintiff's case and is now a professor of law at Georgetown University, told the audience that the "relatively easy" part of the decision was showing that discrimination had occurred when Georgia state officials required two women with mental disabilities to remain in a locked psychiatric ward even though they had been assessed as ready to live in community facilities.

The "hard part" was responding to the state's argument that the state "just can't afford to solve this problem."

Gottesman said that the Supreme Court found a "middle ground" in responding to that question.

According to the decision, states can comply by demonstrating a "comprehensive, effectively working plan for placing qualified persons with mental disabilities in less-restrictive settings and a waiting list that moved at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated" (see box at right).

Tim Westmoreland, a visiting professor of law and a research professor of public policy at Georgetown University, was director of the federal Medicaid program from 1999 to 2001 and worked on the initial implementation of the decision. Medicaid is the major source of public funds for services for those with disabilities.

He commented that only about three-fifths of the states had made progress on their plans, adding, "Many of these plans. . . have vague targets, no timelines, and no connections to state budgets, which of course drive federal Medicaid spending. And, more important, only a few of the states. . .have significantly improved their services in the last five years."

Westmoreland also noted problems with relying on Medicaid as a source of funds for implementation of the *Olmstead* decision. When states have economic problems, as they have for the last three years, state officials cut Medicaid spending, which reduces the federal contribution.

Medicaid "favors institutionalization" in that the provision of nursing home benefits is mandatory, but home and community care benefits are not. In fact, their provision generally requires a waiver from the federal government.

He added, "[W]aivers are a bad thing for people with disabilities because they allow keeping eligible people out, forming waiting lists at the door. . .and also allow very limited services to be provided [despite the fact that federal funds are used]."

States can use waivers to keep some people off the Medicaid rolls because a waiver allows them to stop providing a certain kind of optional service or to stop serving a group of people in exchange for providing different services or service to a different group of people. Since waivers are cost neutral, if beneficiaries or services are added, others must be cut.

Matt Salo, director of the Health and Human Services Committee of the National Governors Association, agreed that the Medicaid program is very much driven by "federal rules and regulations," as well as by state budgets.

He claimed, however, that there had been an "enormous aggressiveness" on the part of the states to do as much as possible to serve people in their homes and communities.

States have obtained more than 220 individual waivers from the federal government to allow them to use Medicaid funds to provide home- and community-based care. Dollars spent on those services total about 32 percent of all spending on long-term care in the Medicaid program.

He added that given the popularity of the waivers, "these should not be waivers any more. We should be allowed to do this without bowing our heads to the federal government."

Tom Perez, assistant professor of law at the University of Maryland, said that he had been hearing from those "in the field" that complaints were not being filed with the Office of Civil Rights about the slow pace of implementation because "there's a sense that there really is no enforcement."

He added, "I don't think the states view the federal government as a credible threat at the moment, and that's one reason you see a lot of inertia out there in some quarters."

"Olmstead *at Five: Assessing the Impact," a report issued by the Kaiser Commission on Medicaid and the Uninsured, and numerous related reports are posted at <www.kff.org/medicaid/kcmu062104pkg.cfm.>.* ■

What Is Community Integration?

The Supreme Court's *Olmstead* decision found that unjustified institutionalization of persons with disabilities is a form of discrimination, but it left considerable latitude about the nature of adequate community integration.

Working under contract with the National Council on Disability (NCD), the Public Interest Law Firm of Philadelphia produced a study titled *"Olmstead:* Reclaiming Institutionalized Lives," which includes comments from people with disabilities about how they view "the most integrated setting."

Those comments were the result of focus groups, informal interviews, and discussions at various state-level meetings about *Olmstead,* according to Martin Gould, NCD's senior research specialist.

When asked to describe "the most integrated setting," the most common response was "a place where the person exercises choice and control." The second most common response was "A home of one's own shared with persons whom one has chosen to live with" or where one lives alone. Respondents also mentioned some variation of the idea that integration is "living in the community with everyone else like everyone else."

What do people with disabilities need to live in the community? They most frequently answered that question by identifying "ordinary human needs," such as friendship, rather than listing services.

Most often, they expressed the idea that "support depends on the person, must be defined by and tailored to the individual, and might change over time."

The second most common response was that people need "friendships, emotional support, and networks of friends, families, and mentors."

Education, opportunities to participate in community affairs, and transportation were mentioned by a number of respondents.

The most important barrier to community integration, according to the respondents, is the lack of affordable and accessible housing.

The National Council on Disability is a presidential-appointed advisory body authorized by the Rehabilitation Act of 1973.

"*Olmstead*: Reclaiming Institutionalized Lives" is posted online at <www.ncd.gov/newsroom/publications/2003/reclaimlives.htm>.

Mixed Verdict on *Olmstead* Follow-Up

In February the National Conference of State Legislatures released the fourth in its series of reports describing the states' response to the Supreme Court's *Olmstead* decision, which required them to place persons with mental disabilities in community settings when the treatment professionals deem that setting appropriate, the individual does not object, and the placement can be "reasonably accommodated."

Authors Wendy Fox-Grage and colleagues wrote that during that four-year period, "new initiatives to better serve people with mental illness have been minimal."

They noted, however, that in the previous year, 18 states described efforts to enhance the quality of mental health services. Among those efforts:

- Arkansas approved a Fiscal 2003-05 biennium budget of $11.6 million to strengthen the mental health system.
- Nebraska enacted the Behavioral Health Reform Act to overhaul the state's psychiatric care system and to shift more funding from inpatient care to community-based care and to eliminate the seven-day waiting period for community-based services.
- New York gave considerable attention to housing for mentally ill people in adult homes, with several state agencies implementing a series of actions aimed at the substandard care for this population.
- Ohio is implementing evidence-based quality approaches for mental health services.

"The States' Response to the* Olmstead *Decision: A 2003 Update" is posted at <www.ncsl.org/programs/health/forum/olmstead/2003/03olmstd.pdf>.

Professional News

Guide Available on Buprenorphine Use

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released what it is calling "the first practical guide" for physicians who wish to use buprenorphine to treat patients who are addicted to opiate prescription pain medications or heroin.

The guide is titled "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction" (Treatment Improvement Protocol 40, or TIP 40). It is a consensus document produced by leading experts in using buprenorphine to treat patients addicted to opiates, SAMHSA noted in a press release.

The guidelines cover screening, assessment, and diagnosis of opioid dependence and its associated problems and determining when buprenorphine is an appropriate treatment option. It also provides information on referrals and self-help programs.

SAMHSA expects TIP 40 to become the basis for training thousands of U.S. physicians to use buprenorphine in office-based settings. TIP 40 also provides guidance to physicians who need to know how to use buprenorphine with patients with co-occurring pain, psychological disorders, or chemical dependency involving more than one substance.

TIP 40 may be obtained by calling SAMHSA at (800) 729-6686. More information on office-based use of buprenorphine is posted online at <www.buprenorphine.samhsa.gov> and <http://alt.samhsa.gov/samhsa_news/VolumeXII_2/index4.htm>. ■

Defeating the Trojan Horse

BY JAMES MAIER, M.D.

Working closely with the Maine Medical Association (MMA), and with financial support from APA, the Maine Psychiatric Association (MPA) successfully redirected a study bill in the state legislature concerning psychologist prescribing privileges to a broader study of access to mental health care.

Maine is following the lead of the New Hampshire Psychiatric Association, which defeated a similar study bill in its legislature earlier this year and fought a successful battle over psychologists' scope of practice last year. APA Medical Director James H. Scully Jr., M.D., has congratulated the MPA for "doing everything right" in response to the prescribing bill.

Storm warnings about a possible bill in the Maine legislature had come from Paula Johnson, deputy director for state affairs in APA's Department of Government Relations, as early as two years ago, and a psychologist bill had been offered but quickly withdrawn last year. But despite a high level of alertness, the MMA and MPA were surprised when state Sen. Mike Brennan, chair of the Health and Human Services (HHS) Committee, submitted "An Act to Allow Psychologists to Prescribe Psychotropic Drugs" in the current legislative session.

Informal consultation with Brennan by MMA Executive Vice President Gordon Smith and others led to a change in the bill's title to "Resolve, To Establish the Commission to Study Access to Prescription Medication for Persons With Mental Illness" (LD 1713).

Brennan asserted that he had not been lobbied by psychologists, but rather had acted out of a genuine concern that people in rural Maine were unable to access prescription medications. However, one psychologist in central Maine had already begun taking courses in psychopharmacology and was quick to jump aboard this "Trojan horse" all too conveniently appearing outside the city gates. Not surprisingly the beast began to roll forward as the volume of out-of-state psychologists' calls to the health committee mounted, despite little enthusiasm from most Maine psychologists.

The MPA was faced with a dilemma. Historically, groups proposing a study bill have come back to the Maine legislature in the subsequent session and succeeded in gaining whatever privileges they were seeking to study. But outright defeat of even this study bill, which was proposed by the Democratic chair of a Democratic-majority committee, seemed a remote political possibility. What to do?

As far back as fall 2002, Maine and Vermont had submitted a grant request to the APA Committee on Advocacy and Litigation Funding (CALF) to hire media strategist Jeff Toorish to develop a small-DB "pre-emptive strike" pilot project to train speakers, educate the public and legislators about who we are and what we do, and even help to develop enabling legislation to consult with and better train medical colleagues.

His expertise as we shifted from a "peacetime" to a "wartime" mode was amplified by the hiring of additional lobbyists Cathy Lee and Andrea Maker (former MPA allies in parity campaigns) and the in-depth knowledge of the legislature provided by MMA lobbyist Andy MacLean and Smith.

A previously planned Psychiatrists' Day at the Legislature just a week prior to the first hearing on LD 1713 offered a well-timed chance to meet with Brennan, other members of the Health and Human Services Committee, and Senate and House leadership. In addition to addressing the standard "talking points" about patient safety, MPA members showcased initiatives we are taking to work with nonpsychiatrist colleagues in rural areas. These include a new telemedicine program led by MPA Legislative Committee Chair Ed Pontius, M.D.; an innovative program proposed by MPA member David Moltz, M.D., to pair MPA members with family practitioners for telephone consultation; and a program of "user-friendly psychiatry" talks at MMA annual meetings.

In addition, we repeatedly pointed out to legislators that the majority of psychotropic prescriptions in Maine are written by medically trained professionals other than psychiatrists and that the distribution of these professionals around the state is wide enough for all to have access to safe prescribing.

These points were restated at the formal hearing on the bill a week later by MPA President William Matuzas, M.D., and by Dr. Pontius, as well as other medical colleagues and overwhelmed the sparser and less-well-prepared testimony of two psychologists. We also submitted editorials and letters to the editor to local newspapers.

The happy outcome of the groundwork laid by the MMA and MPA was a unanimous (including the original sponsor Sen. Brennan!) "ought not to pass" verdict on the bill by the HHS Committee. Better yet, the committee charged the Department of Behavioral and Developmental Services with creating a task force of stakeholders to "address issues concerning access to [mental health] care and collaboration between and among medical care and [mental health] care providers."

Perhaps Maine psychiatrists will now have the proactive opportunity to lead a multidisciplinary force of mental health professionals back to a cash-strapped legislature in its next session to fight together for much-needed services of all kinds for our patients!

Legislative victories do not come cheap. Crucial to defeat of this study bill was strong financial support from APA. The original $45,000 grant from CALF to Maine and Vermont has been used to train speakers and advance educational and advocacy efforts on the prescribing issue, and a second CALF grant allowed MPA to hire additional lobbyists. We urge all APA members to amplify their own DB's efforts by working closely with their state's medical association and by contributing to the recharging of the CALF treasury for the long road ahead. ■

Dr. Maier is the Area 1 representative to the APA Committee on Public Affairs and the MPA's public affairs representative.

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MH Care Benefits Common, But Often Inadequate

Although health insurance frequently provides mental health benefits, access to quality care is confounded by many factors.

BY KATE MULLIGAN

More than three-quarters (76 percent) of the U.S. population in 1999 had mental health benefits as a component of their health insurance plan, according to a report prepared by Mathematica Policy Research Inc. for the Substance Abuse and Mental Health Services Administration.

But that relatively positive finding is complicated by other factors, according to researchers Myles Maxfield, Lori Achman, and Anna Cook.

The generosity of mental health benefits, for example, is affected by whether their source is private or public insurance and by the laws in the state in which they are offered. In the case of employer-sponsored insurance, the generosity of benefits is related to the size of the firm offering them.

In "National Estimates of Mental Health Insurance Benefits," researchers offer answers to such basic questions as these:

- What is the source of mental health benefits? How generous are the mental health benefits for those who have them? How do the limits on benefits vary by source of insurance?

- What proportion of the population falls under the jurisdiction of federal and state parity laws?

What Is Source of MH Benefits?

Mental health care benefits are offered through private and public insurance programs with varying degrees of generosity. The authors offered estimates of the source of primary health insurance in 1999 for those aged 0-17 years and 18-65 years.

Forty-six percent of those in the group aged 17 or younger had private, employer-sponsored health insurance. Other sources of coverage for that group and the percentage of those who had them were Medicaid, 17 percent; State Children's Health Insurance Program (SCHIP), 3 percent; Medicare, 1 percent; and other public insurance, 13 percent. Coverage from outside the household and individually purchased insurance each accounted for 3 percent. Eleven percent of individuals up to age 17 were uninsured.

For those 18 to 65, the figures are private, employer-sponsored health insurance, 53 percent; Medicaid, 5 percent; Medicare, 3 percent; and other public insurance, 14 percent. Individually purchased insurance was 4 percent, and coverage from outside the household was 2 percent. Nineteen percent of these people were uninsured.

The authors estimated that at least 90 percent of the U.S. population who had health insurance had mental health benefits as a component of that insurance, after comparing benefits offered through each type of insurance program with the number of individuals covered by it.

When the number of uninsured people was considered, the percentage of the U.S. population with mental health benefits dropped to 76 percent.

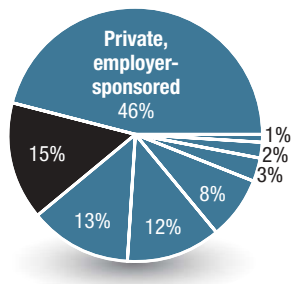
How Generous Are MH Benefits?

The authors defined "benchmark level of generosity" for mental health insurance benefits as coverage for 30 inpatient days, 20 outpatient visits, and prescription drugs.

Lawrence Lurie, M.D., chair of APA's Managed Care Committee, pointed out, "We have to remember that these figures represent a maximum of what a person can receive. When these benefits are managed on the basis of 'medical necessity,' the ac-

please see ***Benefits*** *on page 42*

Where Do Americans Get Their Health Insurance?
(All Age Groups)

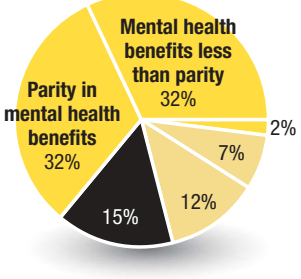


15% **Uninsured**
13% **Medicare**
12% **Other public**
8% **Medicaid**
3% **Individually purchased**
2% **Coverage from outside the household**
1% **State Children's Health Insurance Program**

Note: "Other Public" includes Federal Employee Health Benefits Program, state/local government employees plans, TRICARE, CHAMPVA, VA, and Indian Health Service.

Source: 2000 Current Population Survey

How Many Americans Have MH Parity?



15% **Uninsured**
12% **Mental health benefits of unknown generosity**
7% **Unknown mental health benefits**
2% **Health Insurance with no mental health benefits**

Source: Mathematica Policy Research calculations, 1999

Local Psychiatry Leaders Describe Stresses DBs Face

APA's Board of Trustees hears from two local district branch leaders and votes on a variety of issues.

BY KEN HAUSMAN

As other district branch leaders have done before him in recent years, F. Rodney Drake, M.D., president of the Washington (D.C.) Psychiatric Society (WPS), told the APA Board of Trustees last month that the entwined issues of finances and member recruitment are among the concerns at the top of his district branch's list.

Drake pointed out at the Board's June 26-27 meeting in Leesburg, Va., that to some district branches the WPS's 980 members may sound like an impressive total, but that now represents fewer than half of the psychiatrists in the Washington, D.C., metropolitan area.

WPS leaders are trying to address the recruitment problem, Drake said, by using "breakout groups" of about eight to 10 psychiatrists who meet with district branch leaders and discuss the value of membership and what WPS has accomplished—or hopes to accomplish—for psychiatrists and their patients.

The WPS has also been using a grant from the American Psychiatric Foundation, he noted, to fund a program to convince minority psychiatry residents to join the district branch and APA. It has also expanded resident representation on its board of directors by appointing a delegate from each of the five psychiatry residency programs located in the region.

The Board also invited Eric Steckler, M.D., president of the Northern Virginia chapter of the WPS, to discuss his members' concerns. Steckler lamented the substantial apathy he sees among his members, particularly when it comes to devoting time and energy to lobbying in the state capitol on issues critical to psychiatry and people with mental illness. He stressed that he is often a delegation of one in the corridors of the state house in Richmond.

Referring to the psychologist-prescribing bills that became law in New Mexico and Louisiana, Steckler emphasized the need for district branches to develop strong liaisons with other medical organizations in their state so they can compound the potency of their message when they meet with legislators and maximize the chances that their state will not be saddled with a similar law.

The two leaders were invited as part of a program begun in 1997 by then president Herbert Sacks, M.D., in which a few district branch presidents or minority-caucus chairs are invited to Board meetings to discuss with Trustees key issues on their members' minds.

The Board's agenda for last month's meeting covered a wide array of issues. Among them, the Board voted to

• **Approve a new practice guideline** on assessing and treating posttraumatic stress disorder and acute stress disorder (see below).

• **Join an amicus brief in the case of *Roper v. Simmons,*** which is before the U.S. Supreme Court. The case challenges the constitutionality of allowing states to execute individuals who committed a capital crime while they were 16 or 17 years old. Executions of those aged 15 or younger are already prohibited (see page 1).

Rodney Drake, M.D. (left), is president of the Washington Psychiatric Society, and Eric Steckler, M.D., is president of the Northern Virginia Chapter of the Washington Psychiatric Society.

• **Eliminate the 90-day additional "grace period" that allows members to pay their APA dues up to 15 months beyond the due date.** With this change, members will have to pay their dues within one calendar year of the actual due date—thus still leaving a 12-month grace period—so that they will, for example, have to pay 2003 dues, which were due by December 31, 2003, no later than December 31, 2004, to avoid being dropped from membership.

• **Implement a new structure for determining dues and annual meeting registration fees for international members** based on the wealth of the country in which they reside. There are four categories of countries—high income, upper-middle income, lower-middle income, and low income. International members (there are about 1,120) in high-income countries would pay dues of $180, equal to dues paid by members in the United States in their first three years of membership. Those in upper-middle-income countries would pay $150; those in lower-middle-income countries $100; and those in low-income countries $50. The country classification is the one the World Bank uses and is based on gross national income.

Annual meeting registration fees would be $395, $350, $275, and $200, respectively, for the same four country categories.

• **Establish a work group to review a recommendation from the Assembly that the medical director serve as the Association's chief executive officer.** Currently, the president, who is elected each year, is the chief executive officer, and the medical director is the chief operating officer. The Assembly and many Board mem-

please see ***Leaders*** *on page 43*

PTSD Treatment Focus of Newest APA Practice Guideline

Psychiatrists treating patients with acute stress disorder or posttraumatic stress disorder gain a valuable new tool now that APA has released its latest practice guideline.

BY JOAN AREHART-TREICHEL

A 13th APA practice guideline, Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder, is ready to make its debut. It was approved by APA's Board of Trustees in June.

The guideline is built from the "best evidence-based and clinical-practice knowledge that one could ever imagine assembling," Robert Ursano, M.D., chair of the Work Group on ASD and PTSD, told *Psychiatric News*.

"With the present concerns of the nation for terrorism and the need for all clinicians to be able to help those who experience the ravages of a motor vehicle accident, a rape, or a war, the guideline can assure practitioners that they are using the best possible treatments for their patients."

The practice guideline is divided into three parts: practical guidance and recommendations regarding the assessment and treatment of acute stress disorder and posttraumatic stress disorder; review and synthesis of the research literature from which the recommendations are derived; and future research needs.

Since the document is meant to be taken as a whole, digesting the entire guideline is the recommended course of action, David Benedek, M.D., consultant to the Work Group on ASD and PTSD, said in an interview. But undoubtedly the first part of the guideline—treatment recommendations—will be of greatest interest to most psychiatrists, he added.

Actual work on the practice guideline started in 2002, but planning for the guideline predated that, Robert Kunkle, senior program manager for APA practice guidelines, told *Psychiatric News*. In fact, he added, "It might be safe to say that after 9/11, there was increased awareness of acute stress dis-

please see ***PTSD*** *on page 43*

APA Acts on Statement Explaining Principles for rTMS Use

The International Society for Transcranial Stimulation has drawn up a consensus statement to see that repetitive transcranial magnetic stimulation (rTMS) is used safely. APA has also designated the statement as a resource document.

BY JOAN AREHART-TREICHEL

Repetitive transcranial magnetic stimulation (rTMS) is a rapidly developing technique for the investigation of brain function and the treatment of neurological and psychiatric disorders. In the past decade, for instance, it has gained increasing attention as a promising new therapeutic modality for treating treatment-resistant depression (*Psychiatric News*, May 7).

In light of the growing interest in using rTMS in a variety of experimental and therapeutic settings, the International Society for Transcranial Stimulation drew up a consensus statement to assist the field in developing guidelines for its safe application. Whether the intended use is experimental or therapeutic, certain principles regarding the safety of rTMS apply, the society believes.

The statement is not aimed at guiding the therapeutic use of rTMS or its applications in research, but rather is meant to apply broadly to rTMS use.

The statement is titled "Managing the Risks of Repetitive Transcranial Stimulation" and was published in the July 2003 *CNS Spectrums*.

At its June meeting, the APA Board approved the consensus statement as a resource document. A resource document is a collection of information, data, and reviews of the literature developed by APA components and staff that are seen as useful and needed by APA and members and by the field. The findings, opinions, and conclusions of the statement do not necessarily represent the views of the officers, trustees, or all APA members.

The consensus statement defines rTMS specifically as the administration of a series of magnetic stimuli to the brain for the purpose of altering brain function and specifies that rTMS is an experimental medical intervention under investigation as a potential treatment for neurological and psychiatric disorders, indicates that epileptic seizure is a significant risk of rTMS, and provides principles for safe administration of rTMS.

To reduce risks associated with the use of rTMS, the consensus statement recommends the following:

• rTMS should be administered only by or under orders of a licensed physician.
• Those who administer the procedure must be trained as "first responders."
• The procedure must be administered in a medical setting.
• The dosage must be limited by published safety guidelines.
• Administration must be in compliance with regulations issued by regulators and professional medical organizations.

The resource document will soon be posted on APA's Web site at <www.psych.org/public_info/libr_publ/resource.cfm>. ■

APA Honors Contributors To Mental Health Field

Through their work—whether it is research, film, books, legislation, or advocacy—APA's 2004 awardees are making significant strides in improving the lives of those with mental illness.

BY EVE BENDER

Psychiatrists, film directors, journalists, and researchers are part of an eclectic group of professionals who were honored at APA's 2004 annual meeting in New York in May for their dedication to psychiatry and mental health causes.

Each year APA honors a number of individuals who have worked to improve the lives of people with mental illness in many ways, such as clinical practice, research, and public policy and advocacy work.

These are the honorees and the awards they received, as listed in the program book of APA's 48th Convocation of Distinguished Fellows:

William C. Menninger Memorial Convocation Lecture: *Tom Wolfe*, an author best known for his national best-sellers *The Right Stuff*, *The Electric Kool-Aid Acid Test*, and *Bonfire of the Vanities*.

Special Presidential Commendations: *Martha J. Kirkpatrick, M.D.*, clinical professor of psychiatry at the University of California at Los Angeles (UCLA); *John S. McIntyre, M.D.*, APA past president and Assembly speaker, vice president for behavioral health and chair of the department of psychiatry and behavioral health at Unity Health System in Rochester, N.Y; *Jessie Nelson*, writer, director, and producer of films such as "Corrina, Corrina" and "I Am Sam"; *Herbert S. Peyser, M.D.*, a clinical professor of psychiatry at Mt. Sinai Medical Center, psychiatric consultant to the Smithers Alcoholism Center of St. Lukes-Roosevelt Hospital Center, and an APA Assembly representative from the New York County District Branch; *Katharine A. Phillips, M.D.*, a professor of psychiatry at Brown Medical School and director of the body dysmorphic disorder program at Butler Hospital in Providence, R.I.; *Joe Yamamoto, M.D.*, professor emeritus of psychiatry at UCLA and clinical professor emeritus at the University of Southern California.

Distinguished Service Award: *Nancy C. Andreasen, M.D.*, the Andrew H. Woods chair of psychiatry at the University of Iowa College of Medicine and editor-in-chief of the *American Journal of Psychiatry; David Satcher, M.D.*, the 16th U.S. surgeon general, who completed his term in February 2002 and served as former assistant secretary for health.

Organizational Distinguished Service Award: *National Mental Health Association*, the country's oldest and largest nonprofit mental health organization, founded by Clifford Beers in 1909.

APA/Lilly Resident Research Award: *Li-Shiun Chen, M.D.*, a PGY-4 psychiatry resident at the Washington University/Barnes-Jewish Hospital; *Karl Deisseroth, M.D.*, a PGY-4 psychiatry resident at Stanford University; *Josette Lindahl, M.D.*, a PGY-4 psychiatry resident at the University of South Dakota; *Michael Rapp, M.D.*, a PGY-2 psychiatry resident at the Mt. Sinai School of Medicine; *Jason Schillerstrom, M.D.*, a PGY-4 psychiatry resident at the University of Texas Health Science Center.

Human Rights Award: *Walter Reich, M.D.*, the Yitzhak Rabin Memorial Professor of International Affairs, ethics, and human behavior at George Washington University, for his work to condemn Soviet abuse of psychiatry to suppress political dissent.

Blanche F. Ittleson Award for Research in Child Psychiatry: *Laurence L. Greenhill, M.D.*, the Ruane Professor of Psychiatry and Pediatric Psychopharmacology at Columbia University and director of the New York State research unit of pediatric psychopharmacology at the New York State Psychiatric Institute.

APIRE/Kempf Fund Award for Research Development in Psychobiological Psychiatry (mentor): *Stephen R. Marder, M.D.*, director of the Department of Veterans Affairs, VISN 22 Mental Illness Research, Education, and Clinical Center, director of the section on psychosis at the UCLA Neuropsychiatric Institute, and a professor of psychiatry at the UCLA David Geffen School of Medicine.

APIRE/Kempf Fund Award for Research Development in Psychobiological Psychiatry (mentee): *Jonathan E. Sherin, M.D.*, an assistant professor of psychiatry at UCLA and staff psychiatrist at the West Los Angeles VA Medical Center.

Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry: *Clarice J. Kestenbaum, M.D.*, a professor of clinical psychiatry at Columbia University College of Physicians and Surgeons.

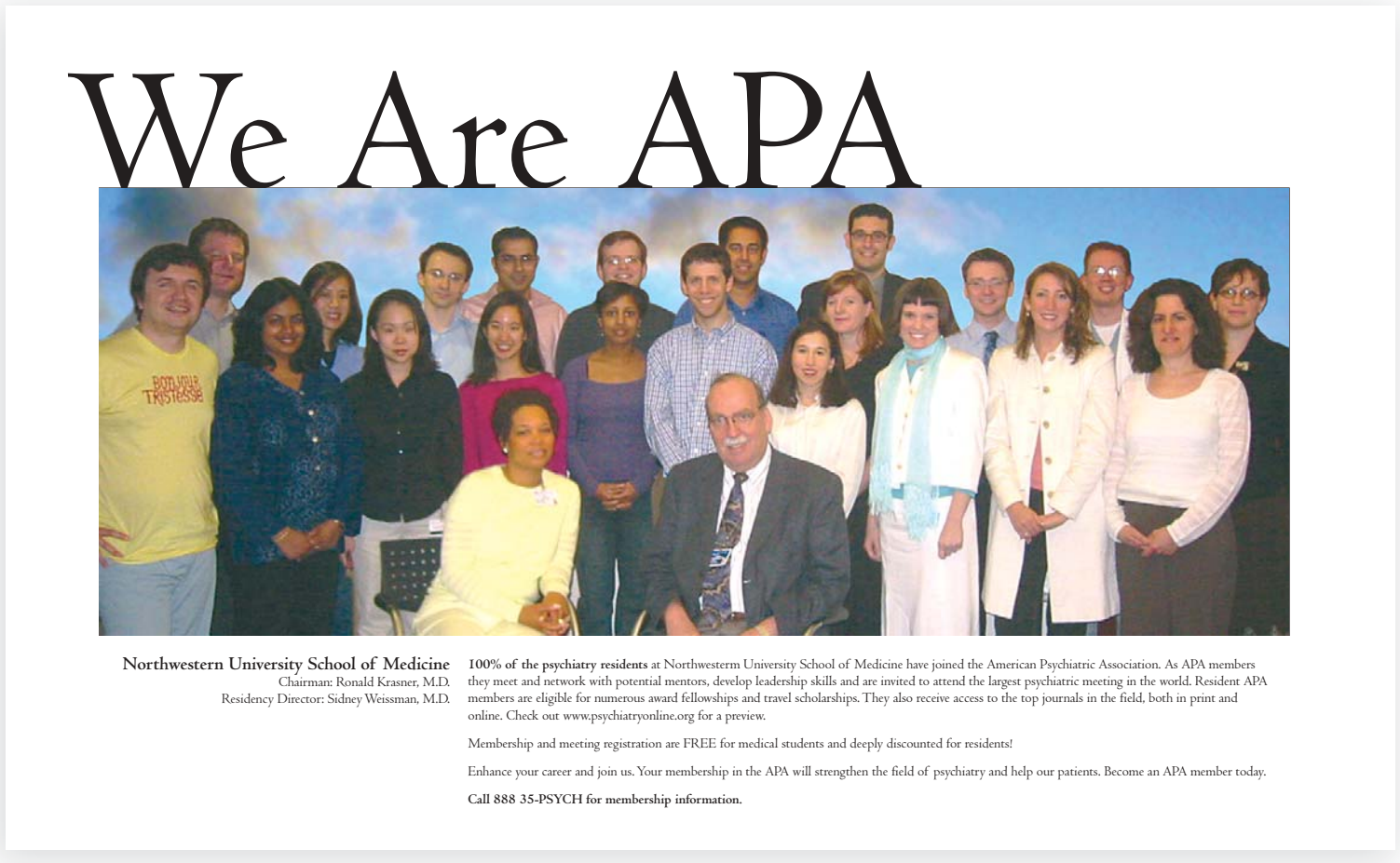
please see ***Awardees*** *on page 43*

Another Residency Program Joins APA's 100% Club

The residency training program in the department of psychiatry at Northwestern University is the seventh program in 2004 to have all of its psychiatry residents become members of APA.

It joins the ranks of an exclusive organization within APA: the 100% Club. This club was established to encourage residents throughout the United States and Canada to join APA and to do so with other trainees in their programs, according to Deborah Hales, M.D., director of APA's Division of Education and Career Development.

The first 10 training programs whose residents all become APA members in the same year can submit a photo of their program members—residents, training directors, and department chair—and the photo will be turned into a poster and mailed to every medical school in the United States and Canada to encourage medical students to join APA.



Back row, from left: Tom Allen, M.D., Farrah Fang, M.D., Tiziano Colibazzi, M.D., Manish Soni, M.D., Chris Stepansky, M.D., Arshdeep Jawandha, M.D., Arron Reichlin, M.D., David Kemp, M.D., Brian Thompson, M.D., and Lisa Siegal, M.D. Middle row, from left: Jakub Juros, M.D., Sonali Nanayakkara, M.D., Janet Kemp, M.D., Betty Wang, M.D., Candice Graham, M.D., Jeremy Kaplan, M.D., Robin Markey, M.D., Katherine Ruhl, M.D., Laura Lee Anders, M.D., Abigail Benson, M.D., and Karen Wiviott, M.D. Seated: Mia Collins, and Sidney Weissman, M.D. (residency director). Not pictured: Ronald Krasner, M.D. (chair), Laura Long, M.D., Ben Bryan, M.D., Shane Spencer, M.D., Eric Wilson, M.D., Teri Carlson, M.D., Afi Eframian, M.D., Robert McCarthy, M.D., and Albert Wu, M.D.

"The faculty of a residency program serve as the model to our residents for involvement in all aspects of our profession," said Sidney Weissman, M.D., director of the residency training at Northwestern. "This involvement requires the faculty's active participation in our professional societies. At Northwestern our chair, Ronald Krasner, M.D., is secretary of the American Association of Directors of Psychiatric Residency Training; our clinical director is on the council of the Illinois Psychiatric Society, our former chair is the treasurer of the Illinois Psychiatric Society and a member of various other professional societies, and I am APA's Area 4 trustee.

"The faculty's participation and commitment to psychiatric professionalism, however, are not enough to engage our residents in the activities of APA. The residents in a fertile academic environment must take the steps to belong. At Northwestern the steps and essential actions to belong to the 100% Club came from the residents and not the faculty. I congratulate all of them and all of the resident members of APA."

More information about the 100% Club is available from Nancy Delanoche of APA's Division of Education and Career Development at (703) 907-8635. Programs that are interested in signing up all their residents should also contact Delanoche. ■

Art Association Members Reveal State of the Arts

Members of APA's Art Association and their partners balanced scientific information for the brain with work for the heart and soul at APA's 2004 annual meeting.

BY SONIA PAWLUCZYK, M.D.

"Give me liberty or give me death" were Patrick Henry's eloquent words pleading the cause of the people. We do not subscribe to the second alternative, death, but we do exhort our colleagues to "give liberty" to the latent artist held prisoner in the unconscious of each of us.

Art lives in the heart of every person. It has survived through the ages because it is indispensable. One paints, sculpts, or writes a poem to set free the vast, new universe of imagery that is held in captivity in the dungeons of our psyche. But beware—this is a seductive world, where even the meekest of objects is emotionally charged, the place where the most trivial things are integrated into a special world. That's "art space." The artist explores this space and translates it using brilliantly symbolic idioms.

The 35th APA Art Exhibit took place in New York City in conjunction with APA's 2004 annual meeting in May. The exhibit was tenderly assembled by members of the APA Art Association, who mustered a wondrous collection of art work. These ranged from embryonic image concepts to pieces of museum quality. The exhibit was popular as evidenced by the many visitors it drew, most of whom became instant art critics and cast ballots for their favorite entries. The APA Art Association was honored that Carol Nadelson, M.D., former APA president, presented the awards.

The association also elected new officers: I was elected president; Wilma Rosen, M.D., is the newsletter editor; Linda Logsdon, M.D., and William A. Alvarez, M.D., are the co-treasurers; and Victoria Kelly, M.D., is the chief exhibit coordinator.

Sonia Pawluczyk, M.D., was the first-prize winner in the color photograph category for "Skultura Comienda Gatorum."

Membership in the APA Art Association is open to APA members and their spouses or significant others ("significant others" are defined as spouses or partners, not children, pets, or others). Further information on membership is available by writing to me at P.O. Box 14449, Long Beach, Calif. 90853-4449.

The following are the names of the exhibit prize winners by category:

Poetry

First and Best of Show: "The Three Bs," William A. Alvarez, M.D.

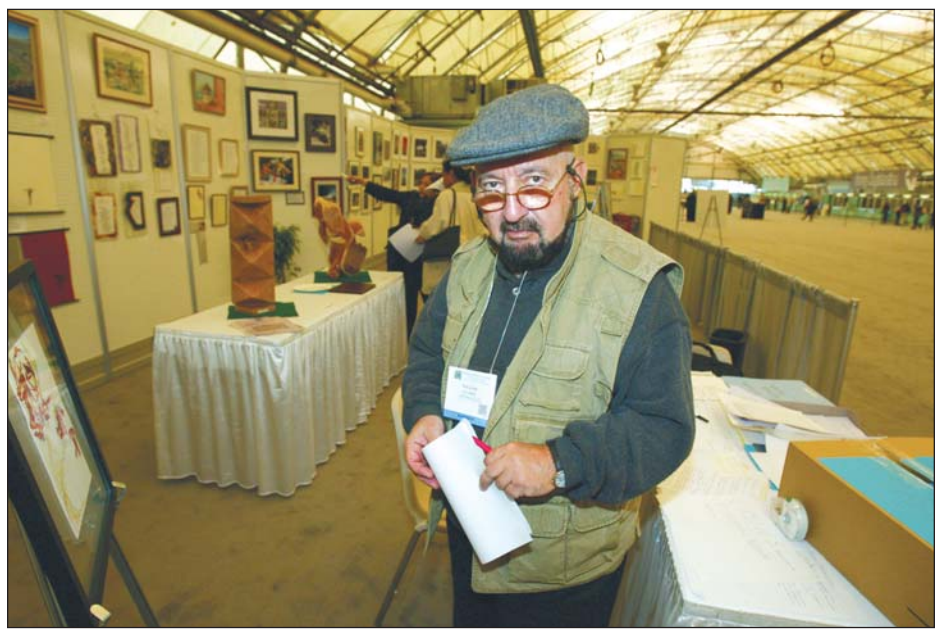
Second: "A Matter of Opinion," William A. Alvarez, M.D.

Third: "Loving You," William A. Alvarez, M.D.

Craft

First: "Basket With Voice," Gail Barton, M.D.

please see ***Arts*** *on page 45*



William Alvarez, M.D., won the Best of Show award and first, second, and third prizes for poetry.

Sonia Pawluczyk, M.D., is president of the APA Art Association.

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APA ALLIANCE OFFERS SUPPORT TO CHILDREN'S AID SOCIETY

Members of the **APA Alliance and their guests** gather at the historic University Club in Manhattan in conjunction with APA's 2004 annual meeting to hear luncheon speaker **Prof. R.J.W. Williams,** a member of the Royal College of Psychiatry, and to install new president **Cathy Tasman** (seated, left) and other new officers.

A highlight of this year's event was that guests were asked to bring an assortment of children's books and stuffed toy animals for donation to the Children's Aid Society of New York. The Alliance wanted to show its support to an organization that has contributed to the mental health of children and their families. The Children's Aid Society of New York offers more than 100 health, education, and recreation services and programs at 38 sites.

Philip Coltoff, chief executive officer of the Children's Aid Society, acknowledged the Alliance's contribution with a letter of appreciation and noted that the books and stuffed animals were given to the East Harlem Children's Community Center. "Your kindness is making a difference in the lives of New York City's children," he wrote.

Tasman suggested that the Alliance luncheon presents an opportunity for members to bring books and toys to be shared with children in need in the host cities of APA's annual meeting. Next year's meeting will be held May 21 to 26 in Atlanta.

'Depression Calculator' Shows Cost of Untreated Illness

APA believes that a new tool that measures the cost to employers of untreated depression and the savings that accrue when workers get treatment will be an eye-opener for corporate decision makers.

BY KEN HAUSMAN

APA has added another element to its multiyear initiative to educate corporate officials and their employees about the financial and other costs of untreated mental illness in the workplace.

This new facet of the effort takes the form of a "depression calculator," a tool that should raise the consciousness of employers about the true costs of depression—consequences such as higher absenteesim, greater costs for other types of medical illness, and lower worker productivity.

APA helped launch the calculator in June in conjunction with the Pharmaceutical Research and Manufacturers of America, which commissioned development of the online instrument.

Employers who access the depression calculator are given a general introduction to depression and its workplace consequences, followed by an explanation of the "productivity impact model" (PI model) upon which the calculator relies to gather and analyze employers' responses.

The PI model, employers are told, will help them determine the incidence of depression in their company and then will predict "the expected number of days each year your employees will be absent or suffer low productivity due to their depression and the associated costs."

The model will also "project the net savings that will accrue with treatment of those employees suffering from depression."

In the first of the depression calculator's four sections, employers are asked to select from responses that describe the size, age, and gender of their workforce and type of business.

The next section provides a chart showing the expected prevalence of depression based on the firm's location and age/gender distribution. Accompanying the chart are descriptions of why these data are important and information critical to diagnosing depression. Then, again on the basis of age, gender, and size of the workforce, the calculator shows how many days workers with untreated depression will miss work on average and the extent of higher medical costs a company is likely to absorb for such employees.

Section three shows employers estimates of how much absenteeism is likely to drop if workers have access to affordable depression treatment, how much the company's incremental medical costs will drop, and the offsetting costs of depression treatment, including "counseling and medication."

The fourth section describes the net financial benefits over a three-year period of "identifying and treating employees suffering from depression." It also creates several charts that summarize the particular

please see ***Calculator*** *on page 43*

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ASTRAZENECA SEROQUEL
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Visitors to the World of Coca-Cola can sample 20 drinks that are not marketed in the United States and sip their favorite Coke beverage at a 1930s-era soda foundation.

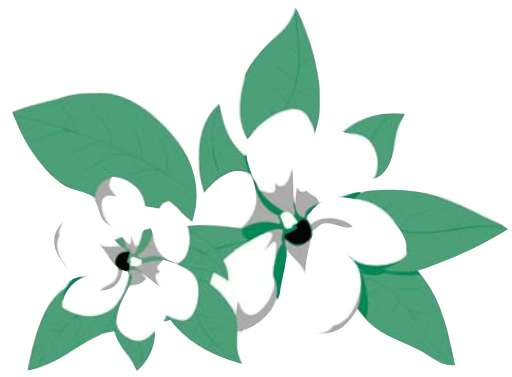
Networking Opportunities Abound In IPS Exhibit Hall

The Exhibit Hall will be the central gathering spot for those attending at APA's 2004 Institute on Psychiatric Services.

APA travels to the heart of the south for its 2004 Institute on Psychiatric Services. The theme of this year's institute is "Mental Health Disparities in the Community."

The institute is often referred to as APA's "other meeting," and many may not know what that means. Where the annual meeting is seemingly immense and all encompassing, the institute is informal, clinically focused, less hectic, and multidisciplinary. Because of its more concentrated size, the meeting offers attendees more opportunities to interact with faculty and network with colleagues, both national and international.

The institute's central gathering point will be the Exhibit Hall, located in Georgia Hall on the lower level of the Hilton Atlanta Hotel. Meeting attendees are welcome to drop by for morning coffee and afternoon receptions. Commercial and educational exhibitors will be available to discuss the latest products and services for psychiatrists and mental health professionals, including pharmaceutical products, computer software, and books. Further, APA staff will be on hand in the APA Member Center and Job Bank to provide an array of services or answer questions.



56th INSTITUTE ON PSYCHIATRIC SERVICES

Many registrants won't go home empty handed. Drawings for valuable prizes will be conducted in the morning and afternoon. This year's prizes include a notebook computer, Palm Pilot, personal copy machine, fax machine, cordless phone, DVD player, digital camera, video camera, stereo, free registration to APA's 2005 annual meeting, free registration to the 2005 institute, color television, dinner for two, and two roundtrip domestic airline tickets.

The exhibits will open at 1:30 p.m. on Thursday, October 7, and close at 5:45 p.m. on Saturday, October 9.

More information about the institute, including a preliminary program, CME course listing, and housing information, is posted online at <www.psych.org/edu/ann_mtgs/ips/04/index.cfm>. ■

Register Now!

A copy of the preliminary program booklet, which includes registration, housing, and air travel information, can be obtained by calling the APA Answer Center at (703) 907-7300 or by clicking on the IPS logo on APA's Web site at <www.psych.org>.

Register in one of three ways:

- Register online by going to the Web site <www.psych.org/edu/ann_mtgs/ips/04/registration/index.cfm> and click on "Register Online."
- Download a registration form at <www.psych.org/edu/ann_mtgs/ips/04/registration/index.cfm> and mail or fax the completed form to APA.
- Use the registration form found in the preliminary program booklet and mail or fax the completed form to APA.

Save on fees by registering before September 6.

TMAP Shows Promise In Depression Treatment

For those with the most severe symptoms and lowest function, algorithm-driven treatment appears to be the best option.

BY JIM ROSACK

A comprehensive algorithm for the use of antidepressant medications appears to help physicians improve outcomes over "treatment as usual" for patients with severe major depression.

The Texas Medication Algorithm Project (TMAP) set out to provide a vehicle for more uniform treatment of mentally ill patients in Texas. The project, begun in 1997, was a collaborative effort by the University of Texas (UT) Southwestern Medical Center at Dallas and the Texas Department of Mental Health and Mental Retardation.

"TMAP is a disease-management program that includes algorithms and other support systems that help physicians make treatment decisions based on a patient's clinical status, history, symptoms, and results up to a specific point," said Madhukar Trivedi, M.D., an associate professor of psychiatry and head of the depression and anxiety disorders program at UT Southwestern.

The original goal of unifying patient care across the state appears to have been rewarded with improved outcomes for patients as well.

Trivedi and his colleagues reported in the July *Archives of General Psychiatry* that use of the TMAP depression guideline is associated with a two- to three-fold greater improvement in patients with depression compared with usual care. The research was funded by numerous sources (see box at right).

"This study, which is the first to show the effectiveness of the TMAP on depression, is powerful and compelling," Trivedi said.

Trivedi and his colleagues followed 547 patients with major depressive disorder at 14 clinics for a minimum of 12 months of treatment. At four of the clinics, patients received algorithm-based care, while the other clinics treated patients according to the clinic physician's usual-care plans. Patients in both groups had on-site clinical support from clinical coordinators and went through an education program for patients and families.

"Both groups of patients received treatment from qualified physicians who had access to the same treatments and medications," Trivedi said. "Therefore, all patients improved. But the level of improvement in the disease-management group was twice as much when measured by a clinician, and three times more improved when the patient described his or her own level of improvement. The outcomes for symptomatic improvement, as well as functional improvement, were dramatically better among patients who followed the algorithm-based program."

Patients were rated on two primary outcomes: symptoms as measured by the 30-item Inventory of Depressive Symptomatology–Clinician Rated Scale (IDS-C) and function measured by the Mental Health Summary Score of the Medical Outcomes Study 12-item Short-Form Health Survey (SF-12). In addition, a secondary measure of improvement was the 30-Item Inventory of Depressive Symptomatology–Self Report Scale (IDS-SR).

Both patient groups saw significant reductions in symptoms during the first three months of treatment, and both groups continued to improve throughout the 12 months of the study. However, the group treated according to TMAP saw an initially greater decline in symptoms in the first three months compared with those treated as usual. The advantage in the TMAP group continued through the 12 months of follow-up—that is, the treatment-as-usual group never caught up to the improvement seen in the TMAP group.

When Trivedi and his colleagues subdivided the patients into groups of very severe depression, severe depression, and mild/moderate depression, they noted an interesting differentiation in TMAP's apparent power. The analyses revealed that the effects were largely accounted for by patients with severe and very severe baseline scores on the IDS-C. The researchers cautioned, however, that the study was not powered to determine a treatment effect based on baseline-symptom severity, so any conclusion that TMAP is more effective in patients with more severe symptomatology is premature.

With respect to improvements in patients' functional status, both groups again improved from the baseline, and improvement continued throughout the 12 months. The TMAP group, again, saw greater functional improvement. Improvement appeared to be greatest for those whose baseline scores were the lowest on the SF-12, regardless of treatment as usual or by TMAP.

The researchers reported that the difference between the improvement in the two groups is clinically significant, noting that the TMAP group on average saw 4.4 points greater improvement on the IDS-C compared with the treatment-as-usual group.

"A 4.4-point difference in IDS-C is roughly equivalent to a three-point difference on the Hamilton Rating Scale for Depression, which is the difference typically found in drug-to-placebo comparisons, yet here we are comparing two active treatments," the researchers wrote.

However, they continued, "despite robust benefits attributable to [TMAP], even among the responders, substantial symptoms remained." Trivedi and his colleagues observed that this "points to the severity, comorbidity, chronicity, or possible treatment resistance in this population." They also wondered whether the outcomes would be different in less severely ill patients.

Finally, the researchers concluded, the study was aimed only "toward optimizing pharmacotherapy and patient adherence. These results suggest the need to study the effects of a broader-based intervention that would integrate evidence-based psychotherapy with evidence-based pharmacotherapy, as well as changes in the health service provision systems, to enhance physician adherence to evidence-based treatments."

An abstract of "Clinical Results for Patients With Major Depressive Disorder in the Texas Medication Algorithm Project" is posted online at <http://archpsyc.ama-assn.org/cgi/content/short/61/7/669>. The depression guideline is posted at <www.mhmr.state.tx.us/centraloffice/medicaldirector/TMAPtoc.html>. ■

Putting Clinical Trial Results in Perspective

With the ongoing controversy surrounding objective reporting of all clinical trial results—both negative and positive—study results should be viewed in context.

Many questions have been raised over potential bias based on a study's source of funding.

The research reported here, comparing the Texas Medication Algorithm Project (TMAP) guideline for the treatment of depression with a "treatment as usual" approach, may be skeptically received in light of allegations earlier this year regarding significant funding from multiple pharmaceutical companies to the TMAP consortium of investigators.

In February it was reported, first in the *New York Times,* that "10 drug companies chipped in to help underwrite the initial effort by Texas state officials to develop the [TMAP] guidelines." The report also noted that "other companies paid for meetings around the country at which officials from various states were urged to follow the lead of Texas." Indeed, these allegations are the root of a "whistleblower" lawsuit in Pennsylvania regarding drug company payments to state officials, allegedly aimed at getting the state to adopt the guidelines, which the suit alleges promote the use of newer, more-expensive, medications over older, less-expensive generics.

According to numerous reports, TMAP received a total of $285,000 from 11 pharmaceutical companies for start-up of the project. In the development of the guidelines for depression, schizophrenia, bipolar disorder, ADHD, and pediatric depression, TMAP to date has spent more than $6 million. The list of funding sources is long, but is included in its entirety in the TMAP depression study reported here.

The current study was funded by the National Institute of Mental Health, along with numerous foundations (including the Robert Wood Johnson Foundation—separate from Johnson & Johnson, but founded by the estate of the long-time CEO), the Texas Department of Mental Health and Mental Retardation, the federal Center for Mental Health Services, and the Department of Veterans Affairs, as well as many others. Numerous pharmaceutical companies contributed unrestricted educational grants to the TMAP depression study.

As psychiatrists and mental health professionals review the TMAP depression algorithm report and attempt to put the results in context, they will likely be reminded of the complexity of conducting a large, multicenter clinical trial in today's research environment.

Major Depression, Enlarged Pituitary: Which Is the Chicken?

Although an enlarged pituitary gland has been found in some teens with a major depressive disorder, the meaning of these findings is still unclear.

BY JOAN AREHART-TREICHEL

Enlarged pituitary glands have been found in some adolescents with early-onset major depression, raising the question of what role, if any, the gland plays in their disorder.

The finding about the enlarged pituitary glands comes from Vivek Kusumakar, M.D., an associate professor of psychiatry at Dalhousie University in Halifax, Nova Scotia, and Frank MacMaster, a doctoral candidate in anatomy and neurobiology at the National Research Council in Halifax. Results appeared in the May-June *Journal of Psychiatric Research*.

Some abnormalities in hormones under the control of the pituitary gland have been noted in individuals with a major depression. For example, a failure to suppress blood levels of the hormone cortisol have been noted in major depression subjects after they were given dexamethasone. And in 1991, Ranga Krishnan, M.D., chair of psychiatry at Duke University, and colleagues found enlarged pituitary glands in acutely depressed adult subjects compared with healthy control subjects. So Kusumakar and MacMaster suspected that they might find enlarged pituitary glands in adolescents with major depressive disorder.

They used high-resolution magnetic resonance imaging (MRI) to measure the volume of the pituitary gland in 17 teens with a major depressive disorder and in 17 gender-matched healthy-control teens. The 34 subjects were, on average, 16.5 years old. A trained rater blind to the diagnosis of each subject conducted the MRI measurements.

The subjects with a major depressive disorder were found to have pituitary glands that were significantly greater in volume—by 25 percent—than were the pituitary glands of the control subjects. And even when the researchers eliminated the three depressed subjects who were on psychotropic medications from their evaluations, they still found that subjects with a major depression had significantly larger pituitary glands than did controls.

"To our knowledge," Kusumakar and MacMaster said, "this study is the first direct comparison of in vivo pituitary volumes between early-onset, adolescent major depressive disorder patients and age- and sex-matched healthy controls, indicating anatomical abnormalities in the pituitaries of these patients."

Since this study was published, MacMaster told *Psychiatric News*, he has con-

please see ***Pituitary*** *on page 40*

PTSD Evaluations in Women Require 'Delicate Balance'

The first step in successful PTSD treatment is screening and diagnosis. Taking a trauma history during the initial visit may help elicit traumatic experiences that wouldn't be volunteered otherwise.

BY EVE BENDER

Not everyone who is subjected to trauma later develops posttraumatic stress disorder (PTSD), but the very fact of being born female puts a person at greater risk, according to a psychiatrist who specializes in women's mental health issues.

The lifetime prevalence of PTSD for women—about 10.4 percent—is more than twice that for men.

Psychiatrists should also be aware that women with PTSD may have unique treatment needs, said Marian Butterfield, M.D., M.P.H., who spoke at APA's annual meeting in New York in May as part of a symposium on women's mental health issues sponsored by the Association of Women Psychiatrists.

Butterfield is an associate professor of psychiatry at Duke University and director of women's mental health at the Durham Veterans Affairs Medical Center.

Seldom do women patients who have sustained sexual trauma volunteer that information when they begin seeing a psychiatrist. The effects of sexual trauma may surface as depression, panic attacks, insomnia, suicidality, somatic complaints, or addiction, she said.

Butterfield urged psychiatrists to conduct a trauma history on patients during the initial visit, but to avoid the elicitation of "excruciating detail," which can be upsetting for patients. "It's a delicate balance on the first interview—avoiding voyeurism and keeping boundaries intact," she noted.

When determining whether a patient has experienced trauma, it is sometimes helpful for psychiatrists to make "normalizing" statements to let patients know that experiencing trauma is not uncommon before asking them if they have ever experienced trauma as a child or adult.

If the patient indicates that she has experienced sexual trauma, for example, the psychiatrist should ask about the relationship of the patient to the perpetrator, when the trauma occurred, the duration of the trauma, and the patient's perception of the effect of the trauma on her life, Butterfield said.

Empathizing with the patient can go a long way in helping her to feel supported, Butterfield emphasized. Many of her patients have relayed stories about "hostile treatment responses" from previous clinicians once they bring up the issue of trauma, she noted, such as not being believed.

"When I ask them how they wish people would have responded," Butterfield said, "often the [desirable response] is as simple as saying, 'I'm sorry that happened to you.' "

While assessing patients for PTSD, it is also critical to assess them for cormorbid disorders such as depression, anxiety disorders, and drug and alcohol abuse or dependence, she said. "Comorbid psychotic symptoms may be underdiagnosed in patients with PTSD" by clinicians, she said, and can include auditory and visual hallucinations in addition to paranoid delusions.

It is also necessary to screen for suicidality, since "PTSD patients are six times more likely to attempt suicide than the general population," she said.

Although further research is needed to understand gender differences in the neurobiology of PTSD, Butterfield noted that the hypothalamic-pituitary-adrenal axis of women's brains may be more reactive in PTSD than is the case for men.

Butterfield pointed out that some women with PTSD have been found to release more adrenocorticotropic hormone and cortisol. "There is some question about whether this response is blunted in men," she noted.

It is also thought that fluctuations of estrogen and progesterone may impact on hormonal modulation in neurotransmitter systems, Butterfield added.

Both medications and psychotherapy are used to treat the symptoms of PTSD. The goal of pharmacotherapy is to reduce symptoms of re-experiencing the trauma, avoidance, numbing, and hyperarousal.

"We want to treat associated comorbidities and improve the quality of life and resilience to stress by reducing the disability, stress, and vulnerability, and also to facilitate nonpharmacologic therapies," Butterfield pointed out.

"It's a delicate balance on the first interview—avoiding voyeurism and keeping boundaries intact."

Selective serotonin reuptake inhibitors (SSRIs) are the first line of treatment for patients with PTSD because they are especially "well tolerated and safe," she said, and tricyclic antidepressants have also been shown to be efficacious.

In instances in which SSRIs don't work for patients with PTSD, Butterfield suggested targeting specific symptoms with different medications. For instance, antiadrenergic agents may work for hyperarousal symptoms, she said, and for paranoia, an atypical antipsychotic is recommended. Anticonvulsant medications may be helpful in reducing labile mood or impulsive behavior.

Although there has not been sufficient research on the efficacy of psychodynamic psychotherapy on PTSD, Butterfield noted, its objective is to explore the personal meaning of traumatic events, to "counter the demoralization that is so inherent in traumatic stress," and to maintain a focus on the trauma.

Two types of cognitive-behavioral therapy have been studied and used in patients with PTSD. One uses systematic exposure to help patients confront feared situations, objects, or images, and the other employs anxiety-management exercises such as breathing, relaxation training, and cognitive restructuring to help patients reduce symptoms of anxiety associated with PTSD. ■

Young Brains Don't Distinguish Real From Televised Violence

The first small brain-mapping study of young children watching violent scenes from televised movies suggests the brain processes the event as a real threat.

BY CHRISTINE LEHMANN

Children are exposed to more acts of violence during their Sunday morning programs than adults are during prime time, say experts on the effect of TV violence on children.

Viewing repeated violent acts on TV often has a negative effect on children's behavior and attitudes. But what happens neurologically when children watch TV violence?

John Murray, Ph.D., a child psychologist at Kansas State University, has studied TV violence in children for about three decades. He is believed to be the first researcher to use functional magnetic resonance imaging (fMRI) in young children to study how their brains react to video clips showing violence. He conducted these studies in the late 1990s.

Murray presented the preliminary findings last month at the Head Start Research Conference in Washington, D.C. Head Start and Early Head Start are federally sponsored child-development programs designed to prepare infants and preschool children from low-income families for school.

"The regions of the brain that were activated suggest that viewing violence is emotionally arousing and engaging, and processed by the brain as a real event," said Murray.

The pilot fMRI study of eight children aged 8 to 13 was conducted at the research imaging center at the University of Texas Health Science Center at San Antonio. The children, five boys and three girls, had no psychopathology and were from middle- to upper-income families living in San Antonio, said Murray. The study was funded by a grant from the Mind Science Foundation in San Antonio.

The children were shown six three-minute video clips for a total of 18 minutes. Two clips showed violent boxing scenes from the film "Rocky IV," and two clips showed nonviolent educational programming: the Public Broadcasting Service's "Ghostwriter" and a National Geographic special. The last two clips were neutral controls consisting of a white X on a blue screen.

Murray showed a clip of a violent boxing scene in "Rocky IV" at the Head Start conference. The match is under way between Drago, a huge, robot-like Russian boxer, and Apollo, his smaller, weaker American opponent. Apollo is injured by Drago's forceful punches but insists on remaining in the match.

The conference audience was mesmerized by the violent second round. Drago easily knocks the wind out of Apollo, who is barely standing. Drago becomes more violent and repeatedly punches Apollo's face and head. The clip ends with Apollo pronounced dead on the floor.

Right Brain Activated

"When that clip was shown to the children in our pilot study, we saw greater activation in right regions of the brain. We thought this might occur, because two previous studies found the right side of the brain processes negative emotional material, and the left side processes positive emotional material," Murray said.

Significant activation occurred in the right region of the amygdala, the area of the brain that senses danger in the environment and prepares the body for fight or flight, Murray explained.

The researchers did not see the expected significant activation in the prefrontal cortex in the pilot study. The frontal area is where thought processes such as association and planning take place.

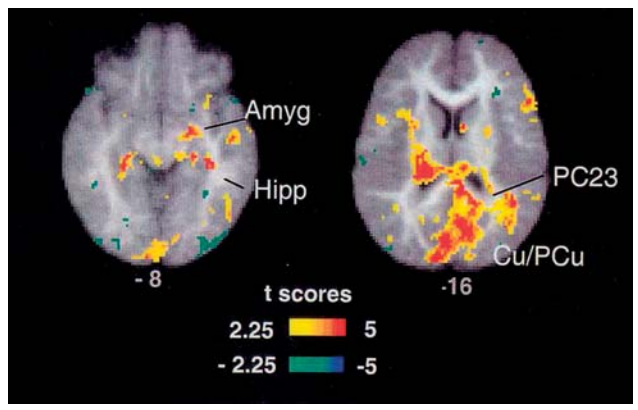
Puzzled by Unusual Finding

The researchers saw pre-motor cortex activation, which they found puzzling. "We knew that children often imitate boxing movements after watching them, which activates the motor cortex," Murray said. "However, the children in our pilot study couldn't physically move inside the fMRI machines. The pre-motor cortex activation suggests they were thinking about moving or perhaps imitating the boxing movements."

Another surprise was the activation in the posterior cingulate, an area in the back of the brain that appears to involve long-term memory storage for significant traumatic events, Murray noted.

Studies of war veterans with severe post-traumatic stress disorder (PTSD) have shown activation in the posterior cingulate when the veterans were asked to recall distressing events and images, Murray said.

"The children in our pilot study were not suffering from PTSD, but they were watching traumatic and dramatic violence. This suggests that the brain processes television violence as an actual threatening event, which is stored in the long-term memory area for quick recall," Murray explained.



The right amygdala (Amyg) and posterior cingulate (PC) in eight children watching violent clips had significant activation (bright orange/yellow areas).

The pilot study had several limitations including a small sample size, Murray acknowledged. Next month, he will begin a larger fMRI study at the Center for Media and Child Health in Boston. This is a joint project with Harvard Medical School and Children's Hospital in Boston.

The study is funded by a $500,000 grant from the federal Bureau of Maternal and Child Health in the Administration for Children and Families, said Murray.

The plan is to enroll 60 children aged 8 through 12 in the one-time fMRI study, with an equal number of boys and girls. The study design is cross-sectional to facilitate comparisons between children with a history of physical abuse, aggressive behavior, and normal development, Murray said.

"I expect the abused children to show greater activation in the right regions of the amygdala, pre-motor cortex, and posterior cingulate. I expect to see less activation in these regions in the aggressive children, who may be desensitized already to suffering and violence because of life experiences," Murray said.

He should know in the next year or two when the study is completed.

Several reports on the impact of television violence in children are posted online

IPT Effective for Depressed Teens In School-Based Setting

Besides being an effective treatment for adolescents with depression, interpersonal psychotherapy translates easily from theory to practice and can be conducted in school health settings, researchers say.

BY EVE BENDER

When compared with adolescents receiving routine treatment for depression in school-based health clinics, those who received interpersonal psychotherapy for depressed adolescents (IPT-A) experienced greater reduction in depression symptoms and improved overall functioning.

This was the major finding of a study examining the effectiveness of IPT in urban schools published in the June *Archives of General Psychiatry*.

Researchers at the New York State Psychiatric Institute conducted the study in five school-based health clinics in impoverished communities in New York City. They gathered data on the mental health outcomes of 63 adolescents referred for treatment to their school's health clinic.

The lead investigator was Laura Mufson, Ph.D., an associate professor of clinical psychology in psychiatry at Columbia University College of Physicians and Surgeons and director of the department of psychology at New York State Psychiatric Institute. She adapted the therapy—which was developed in the 1980s to target depressive symptoms in adults—for use in adolescents.

IPT is a time-limited form of psychotherapy "based on the premise that depression occurs in the context of interpersonal relationships," Mufson told *Psychiatric News*.

While problems in a person's relationships with others may not be the cause of the depression, she noted, they can "exacerbate and prolong depressive episodes."

IPT, she added, focuses on one or two problems within a patient's interpersonal relationships and helps the patient develop better ways of communicating and problem solving within that area of his or her life.

To be eligible for the study, adolescents had to meet *DSM-IV* criteria for major depression, dysthymia, adjustment disorder with depressed mood, or depressive disorder NOS. They also had to have a score of 10 or higher on the Hamilton Depression Rating Scale (HAM-D) and 65 or lower on the Children's Global Assessment Scale.

A child psychologist determined whether students met eligibility criteria after independent evaluators, who were master's-level social workers, assessed children using the Schedule for Affective Disorders and Schizophrenia for School-Aged Children and conducted a clinical interview with the students.

The students were between the ages of 12 and 18, with an average age of 15 years; 84 percent were female, and 71 percent were Hispanic.

If at any time during the study, an adolescent's symptoms or functioning appeared to be worsening—for example, if their HAM-D score was greater than 25—he or she was referred for an evaluation by a child psychologist or psychiatrist and offered an additional treatment such as medication.

Between spring 1999 and summer 2002, 34 students were randomly assigned to receive 12 sessions of IPT-A over 16 weeks, and 29 were randomly assigned to treatment as usual, which typically included supportive counseling on an individual basis.

The mean number of sessions for the treatment-as-usual condition was about eight sessions, according to the report. Eight adolescents received one to three additional family/parent therapy sessions, and five students also participated in group therapy.

Mufson measured depressive symptoms of students in both groups using the HAM-D and Beck Depression Inventory (BDI), global functioning with the Clinical Global Impressions scale and the Children's Global Assessment Scale, and social functioning with the Social Adjustment Scale Self-Report.

At the end of the clinical trial, 17 students, or 50 percent, of those who received IPT-A met the criterion for improvement of depression as measured by the HAM-D as compared with 10 students, or 34 percent, of those who received treatment as usual.

On the BDI, 25, or 74 percent, of those receiving IPT-A met recovery criteria as compared with 15, or 52 percent, who received treatment as usual.

Adolescents who received IPT also fared significantly better on measures of global and social functioning than had those who received treatment as usual.

Mufson said she would like to see the results of the study replicated in a larger sample, and noted that IPT-A is the type of treatment clinicians can learn and con-

*please see **IPT** on page 39*

Education Is Key to Managing Practice Risks

Q. I practice in California and would like to attend a risk management seminar in my area. Will the Psychiatrists' Program be presenting any risk management sessions on the West Coast?

A. Yes. The Psychiatrists' Program will be presenting a risk management session during the 16th Annual California Psychiatric Association Premier Conference. The seminar, titled "The Monster in the Closet: Professional Liability and Risk Management in the Practice of Psychiatry," will be conducted in two parts on Saturday and Sunday, October 9 and 10, from 7 a.m. to 9 a.m. Jacqueline Melonas, R.N., M.S., J.D., vice president of risk management at PRMS, will present the seminar.

This seminar will focus on high-risk areas of psychiatric practice and how to reduce related professional liability risks by using risk management strategies.

As a benefit of participation in the Psychiatrists' Program, attendees of this seminar are eligible to earn a 5 percent premium reduction on their Program insurance premium. Program participants are encouraged to call their underwriter at (800) 245-3333 with any questions regarding the risk management discount.

The meeting will be held at the Napa Valley Marriott in Napa, Calif. To register for the CPA Premier Conference, please contact the California Psychiatric Association directly at (916) 442-5196 or download a conference registration form at <www.calpsych.org>.

The Psychiatrists' Program will also be presenting an all-day risk management seminar titled "Staying on Track: Risk Management Strategies for Psychiatric Practice" on Friday, September 17, at Oak Brook Hills Resort, Chicago/Oak Brook, Ill.

To obtain more information or to register, visit <www.psychprogram.com> or call (800) 245-3333, ext. 310.

Q. I have been reading with some anxiety the increasingly critical media coverage of certain psychotropic medications and the recent FDA Public Health Advisory about prescribing antidepressants. I have a number of patients for whom these medications work well; however, the patients are also aware of the current controversy. What risk management advice is there for continuing to prescribe these medications?

A. The efficacy and safety of psychotropic medications, especially in pediatric patients, is an ongoing issue in clinical practice and psychopharmacological research. These issues have received increased attention recently, due in part to strong advisories and safety warnings from the FDA, certain research findings, and numerous reports in the media, which often emphasize the problems and not the benefits of these drugs.

Specific concern about the off-label use of psychotropic medications to treat children, especially younger children, has been voiced by experts and the public. Most recently the debate about prescribing psychotropic medications has focused on the events leading up to the FDA's March 22 Public Health Advisory on the possibility of worsening depression and suicidality in patients being treated with antidepressant medications *(Psychiatric News*, April 16).

Against this background, physicians' prescribing decisions have the potential to be scrutinized more than ever. Accordingly, psychiatrists should consider using the following risk management strategies to increase patient safety and minimize professional liability risk:

- **Stay informed about the medications you prescribe.** In addition to sources you frequently use (peer-reviewed or published studies, continuing education courses, professional publications, and so on), the FDA's Medwatch Web site, <www.fda.gov/medwatch/safety.htm>, provides updated safety information about drugs.

- **Periodically re-evaluate the medications you currently prescribe and the clinical basis for prescribing.** Update treatment plans and recommendations accordingly. Changes in medications or dosages, reassessment of patients, and closer monitoring of patients and side effects of medications may be required, among other clinical interventions. Consultation or getting a second opinion on patients with complicated psychopharmacology issues should be considered.

- **Use the psychotherapeutic process to discuss important issues with patients.** Examples of the subjects that should be discussed are diagnosis, medication properties, the physician's previous experience with this medication, special concerns of the patient and the patient's family, comorbid somatic conditions, and the patient's and family's expectations about treatment.

- **Update informed consent.** New or updated information about the risks and benefits of using a particular psychotropic medication should be discussed and incorporated into the patient's informed consent. On the basis of updated information, some patients may decide to opt out of some treatments, try alternative medications or treatments, or choose another option.

- **Document.** Document the clinical assessment and clinical judgment that form the basis for treatment recommendations and prescribing decisions. Document significant information about communications with patients and families regarding treatment plan recommendations, including medications. Document the patient's informed consent including the discussion of the nature of the proposed treatment, risks and benefits of the proposed treatment, alternatives to the proposed treatment, risks and benefits of the alternative treatments, and risks and benefits of doing nothing.

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

letters to the editor

Schizophrenia Study

I strongly object to the publication of articles such as "Schizophrenia Risk Linked to Flu Virus Exposure" that report findings from a study that has not yet been peer reviewed for publication in a scientific journal. Investigators have for more than a hundred years looked for physical cause factors in schizophrenia, and they have, like this study, produced correlational data with no consideration of intermediate or intercurrent variables.

The matter of causal factors in schizophrenia is too important to raise false hopes on the basis of inadequately evaluated research.

ALBERT ROTHENBERG, M.D.
Canaan, N.Y.

Anti-OCD Suggested

Musical hallucinations with an emphasis on perceiving music falsely, humming to oneself, or recollecting music appear to be most common in obsessive-compulsive disorder (OCD) patients, according to an article in the May 21 issue.

Neurobiological features are suggested by cognitive inflexibility after prefrontal serotonin depletion manifested by perseveration seen in OCD patients. These findings support initiating a psychopharmacologic trial with an anti-OCD agent (for example, an SSRI) rather than an antipsychotic agent, according to H.F. Clarke and colleagues. They are the authors of the article "Cognitive Inflexibility After Prefrontal Serotonin Depletion," which appeared in the May 7 *Science*.

ERNEST H. FRIEDMAN, M.D.
East Cleveland, Ohio

One-Trick Training?

After I received my 50-year distinguished fellow award at APA's 2004 annual meeting in May, there was time for thought on the flight back to New Mexico and my practice. APA has become a polarized organization, perhaps a reflection of the larger society, but it has tilted too far toward the advocacy of unsupported "biologic" diagnostic and treatment practices that corrode its efficacy and leadership.

We have trained a generation of psychiatrists who are "one-trick ponies," with no arrows in their quiver after pharmacy and "rational polypharmacy" fail their patients. Perhaps that is why we are so threatened now that New Mexico and Louisiana have granted prescription privileges to psychologists.

It is ironic that we are witnessing serious challenges to the scientific integrity of studies supporting the FDA approval of the SSRI class of antidepressants at a time when an unsilent majority of us go along with the pretense that this is evidence-based psychiatry. The editors of *Lancet* wrote in the April 4 issue that "selective reporting of favourable research should be unimaginable."

It is too easy to fault the drug companies. There are too many of us whose integrity has been compromised by grant support or honoraria for the rest of us to be able to trust their advice. The late George Engel, M.D., whom many of us consider the primary advocate of the biopsychosocial approach, would consider current statements about neuro-bio-chemical-genetic causality of mental disorders regressive.

I consider myself fortunate to be able to continue to practice psychiatry now that I am retired from teaching and lucky that I received my award before the name of APA changes, perhaps to the American Bipolar Association.

ALEX BRAIMAN, M.D.
Farmington, N.M.

Readers are invited to submit letters not more than 500 words long for possible publication. *Psychiatric News* reserves the right to edit letters and to publish them in all editions, print, electronic, or other media. Receipt of letters is not acknowledged. Letters should be sent by mail to *Psychiatric News,* APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209 or by e-mail to pnews@psych.org. Clinical opinions are not peer reviewed and thus should be independently verified.

residents' forum

Homeless Outreach Program: A Resident's Perspective

BY JOSE VITO, M.D.

I started my rotation at the Homeless Outreach Team (HOT) on a very cold Tuesday in January. The HOT clinical program provides case management to the chronic homeless population who live on the streets of the Bronx, N.Y.

Outreach workers and case managers canvass the streets of the Bronx 24 hours a day, seven days a week, providing assistance with basic needs such as food and linkages to mental health, substance abuse, and medical services, with the ultimate goal being placement in permanent housing.

After taking the D train a few stops past Yankee Stadium, I met the program director in the dark basement office of the HOT headquarters.

Following a brief orientation, I was informed that I would be accompanying two case managers in the field to begin immediately seeing clients among the homeless population. Armed with a handful of charts, I was ready to begin. The case managers who rode in the van with me were extremely friendly. As a PGY-3 resident, my heart was beating in anticipation of what was going to happen next. I guess they noticed the perspiration, which defied the cold weather, trickling down my forehead as we approached my first homeless client. They assured me that I would be fine.

The first homeless person we encountered was sprawling on the steps outside the number 5 train station, soaked with his own urine. He appeared guarded when I approached him for the history. Since the case managers were familiar to him, I was able to engage him and establish rapport. Besides being a chronic alcoholic and homeless for 20 years, he had been hospitalized numerous times for schizophrenia. The case manager later told me that this client always presented a challenge because of his inability to complete a short-term detoxification program. The team had taken him to detox programs on many occasions, yet after only a couple of days he ended up back on the streets. Luckily, because of the cold, he agreed to go to the shelter on that day.

It doesn't always work that way. Sometimes the case managers have to accept that the client wants to remain on the streets. Client-worker relationships are built gradually on trust and are easily broken if a case manager pushes too hard or too fast.

I asked the case manager if she felt frustrated when homeless clients continually refuse assistance or return to the streets. She said that her reason for doing this job was because she cared and that managing one's own feelings is an essential skill for anyone who works with this population. She quickly added that the outreach team has helped hundreds of people get off the streets and into housing, where they gain stability and are encouraged to re-enter the community as productive members of society.

During my six-month rotation, I learned that there is limited access to appropriate mental health care for the homeless community. The borough has only one drop-in center that provides services, and overnight shelters do not have the capacity to provide mental health care.

I also learned that on any given night in New York City, approximately 30,000 people are homeless. An estimated 30 percent to 50 percent of them have mental illness. These individuals typically do not have strong social supports, and their symptomatology precipitates disruptions in relationships that often contribute to homelessness. Such symptomatology can also translate into an inability to seek help.

There is a severe shortage of psychiatrists providing care to homeless individuals. That shortage and the resistance of many homeless individuals to seeking treatment have created an acute problem for providers of homeless services. Psychiatry residency programs have the opportunity to address the shortage by encouraging psychiatry residents to work with homeless individuals early in their career. This would help alleviate the acute shortage and provide a valuable learning experience for residents.

Throughout my rotation at HOT, I was encouraged to focus on the important issues that emerge for psychiatrists working with the homeless. This experience confirms my passion for the well-being and welfare of the homeless population. Without this component in my psychiatric training, I never would have been exposed to such a challenging and "real" setting. This experience added a new dimension to my studies and greatly expanded my perspective. ■

Jose Vito, M.D., is a third-year resident at Albert Einstein College of Medicine Bronx Psychiatric Center. He is also a vice chair of his district branch's Committee of Residents.

government news

Insurer

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icy—a draft that is preliminary to a local coverage decision—written by the company.

What Godbole saw was alarming. "I called a number of hospitals and pointed out that it is very proscriptive," he told *Psychiatric News.* "But nobody had heard anything about it."

He said the amount of documentation required and the detailed micromanagement of all manner of routine inpatient psychiatric practices—including, for instance, how physicians' orders were to be written—was extraordinary. "It was pretty much telling physicians how to practice," he said.

Godbole is chair of the department of psychiatry at Advocate Illinois Masonic and Bethany Hospitals, Chicago.

A letter from APA, NAPHS, and AHA to Administar in January outlined objections to the draft. "We believe that the draft. . .restricts benefits that are otherwise available under the Social Security Act, imposes arbitrary and in some instances vague criteria that have little to do with the medical necessity of a proposed treatment, and would be unworkable," the letter stated. "Many of the proposed policies are inconsistent with the Social Security Act, [are] not supported by clinical or other data, and would undermine the act's coverage of those in need of inpatient psychiatric treatment."

Godbole said he believes that since hospital psychiatrists are now becoming aware of the issue around local coverage decisions formulated by fiscal intermediaries, the tide is turning toward greater cooperation with physicians and more appropriate policies.

He added that psychiatrists' concerns about the issue have been communicated to CMS, which has been receptive. And both Administar and Associated Hospital Service have agreed to honor a moratorium on enforcing their policies until comments have been received and to work with physicians to arrive at more acceptable policies.

Meyers indicated that APA would press its concern with the LCD with Mutual directly, with the appropriate CMS regional offices, and with the CMS and the Department of Health and Human Services in Washington, D.C. "Hopefully, we can present a strong case to CMS about why this rule should be withdrawn," he said.

The Mutual of Omaha LCD is posted online, with a link to a page for writing comments, at <www.mutualmedicare.com/lmrp/draft.html>. ■

IPT

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duct easily within a number of school health clinic settings.

"We were able to train the clinicians from the schools that participated in the study to conduct IPT-A with a brief training program and supervision, and they were able to implement the study with good fidelity," she said.

The study was funded by the Substance Abuse and Mental Health Services Administration and the National Institute of Mental Health Child Psychiatry Intervention Research Center.

An abstract of the article, "A Randomized Effectiveness Trial of Interpersonal Psychotherapy for Depressed Adolescents," is posted online at <www.archgenpsychiatry.com>. ■

Executions

continued from page 1

jury sentenced Simmons to be executed, but the Missouri Supreme Court negated the sentence citing his age and the U.S. Supreme Court's reasoning in *Atkins* as grounds for setting aside the death sentence. It instead sentenced him to life in prison without the possibility of parole.

The Missouri Supreme Court stated that the issues of reasoning and judgment capacity in teens younger than age 18, based on evidence provided by experts, pointed to the need to extend the issues that determined *Atkins* to 16- and 17-year-olds who commit capital crimes.

In the brief, APA and the other amici emphasize that sophisticated brain-research techniques have shown anatomical factors in teenagers that render them less able to make mature judgments, assess risk, and appreciate potential consequences of their actions.

"Adolescents, even at the age of 16 or 17, are more impulsive than adults. They underestimate risks and overvalue short-term benefits. They are more susceptible to stress, more emotionally volatile, and less capable of controlling their emotions. In short, adolescents cannot be expected to act with the same control or foresight as adults," the brief points out.

"Adolescent brains are more active in regions related to aggression, anger, and fear, and less active in regions related to impulse control, risk assessment, and moral reasoning than adult brains," the brief explains. It goes into detail about the role of brain regions such as the frontal lobe and the amygdala in controlling behavior and emotions. And the regions associated with impulse control and risk assessment are the last to develop, not reaching maturity until after late adolescence.

The brief also emphasizes that the life many adolescents endured before they were arrested can compromise their functioning and decision-making abilities even further.

"To the extent that adolescents who commit capital offenses suffer from serious psychological disturbances that exacerbate the already existing vulnerabilities of youth, they can be expected to function at substandard levels," APA and the other amici said.

These psychological issues can often be traced to growing up in dysfunctional families, witnessing or being victims of violence, or suffering a brain trauma.

Teenagers who have experienced these severe stressors "cannot be presumed to operate even at standard levels for adolescents," the brief emphasizes. It also cites research studies that have found that adolescents sentenced to death for capital crimes are more likely to have endured these harmful experiences than other adolescent offenders.

The amicus brief's final argument is that executing 16- and 17-year-old offenders fails to serve the goal of the death penalty—to punish as severely as possible the calculating, cold-blooded, adult murderer. Putting these teens to death "is to hold them accountable not just for their acts, but also for the immaturity of their neural anatomy and psychological development," it states. This puts such executions in the category of cruel and unusual punishment and thus violates the U.S. Constitution's Eighth Amendment ban on such practices, as the Missouri Supreme Court ruled.

Metzner pointed out that the brief avoids comments on the death penalty as social policy or a moral issue, concentrating instead on the science on which APA has expertise to offer the Court.

As of July, 19 states still allowed execution as a sentence for 16- or 17-year-olds—14 states allowed 16-year-olds to be executed, and five permitted it only for those aged 17 or older.

In addition to APA and ASAP, the American Medical Association, American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, and National Mental Health Association have signed onto the amicus brief.

The Court is expected to hear oral arguments in *Roper v. Simmons* during its next term, which begins on the first Monday of October.

The Missouri Supreme Court decision is posted online at <http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=mo&vol=/supreme/082003/&invol=10826_103>. The amicus brief that APA joined is not yet available online. ■

Professional News

NIH Expands Web Information

The National Institutes of Health (NIH) has implemented a substantial expansion of its health information Web site at <http://health.nih.gov>.

The new features provide visitors with an opportunity to test their knowledge of health-related topics and expand the links to other information on Web sites of NIH's 27 institutes and centers. The added features target topics to a variety of age groups including children, teenagers, adults, and seniors and will supplement information already on the site that is geared to researchers, clinicians, and educators.

The highlights of the expanded Web site, according to NIH, are three new sections—Healthy Lifestyles, Research in Action, and Now Online.

Healthy Lifestyles will link visitors to timely topics such a seasonal health concerns and weight-loss and nutrition information.

The Research in Action section links to "cutting-edge scientific information" on topics in the news such as stem-cell research and introduces readers to scientists who may be teenagers or leading lights in their field.

Now Online contains interactive features and special Web exhibits, such as a recent program on the Milk Matters campaign, which hopes to boost calcium consumption among children and adolescents. ■

WPA

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ing part in the mistreatment of Falun Gong members who were not mentally ill. During a 2000 visit to China by then APA president Allan Tasman, M.D., and other APA leaders, the Americans informed their Chinese counterparts about their concerns regarding the allegations of abuse of Falun Gong adherents *(Psychiatric News*, June 16, 2000).

In 2001 the Royal College of Psychiatrists voted to urge the WPA to send an investigative team to China and assess the validity of charges of psychiatric mistreatment of Falun Gong members.

The Chinese government had outlawed Falun Gong in July 1999, saying its millions of adherents—by some estimates there as many as 70 million—are part of a subversive religious cult. Its practitioners say that it is a spiritual discipline that tries to improve mind, body, and spirit through meditation, controlled breathing, and physical exercises.

In August 2002, at a meeting in Japan, WPA members passed a resolution to send a team to investigate the charges about psychiatric abuse. A year earlier Britain's Royal College of Psychiatrists took a similar position.

The CSP agreed to cooperate with an investigation of alleged psychiatric abuses involving Falun Gong that was to begin in April. Several days before it was to start, the CSP sent Okasha a letter in which it indicated that it was, at the Chinese government's insistence, postponing indefinitely acting on its earlier agreement to participate in a visit from WPA members, since the visit was to be more investigative than educational.

The Chinese government's reneging on the verification visits is a "bad decision," Eist stated, because officials sacrificed an opportunity "to remove a lingering cloud of suspicion that they could have dealt with."

Arthur Kleinman, M.D., a professor of medical anthropology and psychiatry at Harvard, told *Psychiatric News* that the charges of psychiatric abuse of Falun Gong members are exaggerated and some of the accounts "distorted." Many cases came to light in which Falun Gong adherents appeared to have a diagnosable mental illness, including obvious symptoms of psychosis, "and were put in psychiatric hospitals for good reasons," he noted.

While Kleinman acknowledged that some instances of abuse of psychiatry no doubt occurred, he did not believe that they were "systematic," as some some people had charged. "There is a very low level of professionalization regarding forensic and ethical issues" among Chinese psychiatrists, he said, and the low level of clinical and forensic expertise is the "real problem" and at the root of many cases of substandard or unacceptable treatment in Chinese psychiatric hospitals.

"I think the Chinese are quite open to improving" their standard of psychiatric training and care, Kleinman noted. A WPA mission that was more of an "inquisition" than educational outreach "would have been detrimental to all sides," he added.

Critic Cites Mild Tone

Abraham Halpern, M.D., is among the U.S. psychiatrists who are distressed about what they contend is the mild tone of the WPA-CPS agreement.

"The WPA's decision to cancel its demand for an investigative mission undercuts and renders meaningless its past high-sounding declarations concerning misuse of psychiatry," he told *Psychiatric News*. "The allegations of psychiatric abuse in China involve mistreatment, torture, and fraudulent diagnoses in the case of large numbers of political dissidents and Falun Gong practitioners and should not be dismissed as mere 'failures in accurate diagnosis.' "

Halpern is honorary chair of China Mental Health Watch, which was formed in 2003 to "investigate and bring to light the ongoing persecution of Falun Gong practitioners, with particular focus on the effects of psychiatric abuse. . . ." Halpern is also a professor emeritus of psychiatry at New York Medical College and a former president of the American Academy of Psychiatry and the Law.

Agreement Looks to Future

Darrel Regier, M.D., director of APA's Office of Research and the American Psychiatric Institute for Research and Education, called the agreement between the WPA and CPS an "unprecedented accomplishment" in that an official Chinese organization acknowledged errors in diagnosing and treating Falun Gong practitioners and promised to correct them."

Regier also stressed that APA considers the May agreement in which the CPS asked for education and advice from the WPA an important opportunity "to enhance the scientific basis of psychiatric practice in China."

The chair of the APA Council on Global Psychiatry and a former APA president, Rodrigo Muñoz, M.D., told *Psychiatric News* that he is "delighted" that the WPA and CPS were able to arrive at an agreement on the Falun Gong abuse charges. APA, he said, "has been encouraging the Chinese psychiatric leaders to make sure the Chinese Psychiatric Society is truly independent from the government. They are listening to us. This may not be the time to turn on them and blame them for actions by [the Chinese] government."

Muñoz rejected the suggestion by some U.S. psychiatrists that the WPA should expel the CPS. "I hope we have left in the past. . . the tendency to punish rather than talk," he said. "We would like to be in a position to help those in other countries who share the same values we so much appreciate." ■

Pituitary

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ducted another study with David Rosenberg, M.D., of Wayne State University, in 25 teens with a major depressive disorder and 25 healthy control subjects, and this time none of the depressed teens were on medication. Again, MacMaster said, larger pituitary volumes were found in the depressed teens.

The question that still needs to be answered is what the enlarged pituitary glands in depressed youth mean. Do they contribute to the depression? Do they stem from it? And do they lead to abnormal hormone production in the body? For instance, one might expect abnormally high levels of cortisol in the blood to occur if a pituitary gland were abnormally large in volume. Yet while abnormally high levels of cortisol have been noted in adults with major depressive disorder, such high levels appear to be rare in teens with the disorder.

In any event, "the findings are interesting and confirm our earlier reports in adults," Krishnan told *Psychiatric News*.

To date, only a few studies have examined the size of the pituitary gland in psychiatric illnesses. Abnormally small pituitary glands have been noted in bulimic patients and in children with obsessive-compulsive disorder, and abnormally large pituitary glands have been reported in subjects with alcohol dependence.

The study was funded by the Nova Scotia Health Research Foundation and the Theodore and Vada Stanley Foundation.

An abstract of the study report, "MRI Study of the Pituitary Gland in Adolescent Depression," can be accessed online at <www.sciencedirect.com/science/journals> by clicking on **Journal of Psychiatric Research.** ■

PFIZER GEODON IM
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Benefits

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tual benefits available to patients might be much smaller."

The authors noted that the level of benchmark coverage represents a level "typical of many health plans" and not a "measure of plan adequacy."

In 1999 approximately 59 percent of individuals with private, employer-sponsored health insurance provided through a firm with 10 or more employees had mental health coverage that met the benchmark. The authors do not have benchmark data on smaller firms, but noted that the likelihood of meeting the benchmark increased with firm size.

The authors categorized the traditional Medicare benefit as not meeting the benchmark because at the time of the study, Medicare did not provide prescription drug benefits. However, they estimated that 62 percent of Medicare beneficiaries had some prescription drug coverage through another source and, therefore, met the benchmark.

Children covered by Medicaid are eligible for services meeting the benchmark. Six states did not meet the benchmark because of utilization limits for adults, according to the authors. The authors noted that although payment for inpatient care in psychiatric hospitals is excluded by federal law, states provide inpatient psychiatric care in general hospitals.

Federal programs including the Federal Employees Health Benefits Program (FEHBP), TRICARE, Veterans Affairs (VA) health services, and the Civilian Health and Medical Program of the VA (CHAMPVA) met the benchmark.

Approximately 52 percent of individuals with health insurance had mental health benefits that met or exceeded the benchmark.

When the uninsured are included, that figure dropped to 44 percent of the U.S. population who had mental health benefits that met the benchmark.

What Is Extent of Parity?

The authors stipulated that full financial parity requires mental health benefits to be the same as medical and surgical benefits in terms of dollar limits, utilization limits, and cost-sharing requirements.

In 1999 approximately 14 percent of individuals with private, employer-sponsored health insurance provided through a firm with 10 or more employees had full parity in their mental health benefits.

As firm size increased, firms were less likely to provide parity in mental health benefits. The authors speculated that larger firms are more likely to be self-insured and thus not subject to state mental health parity laws because of the Employment Retirement Income Security Act (ERISA).

ERISA exempts self-insured employer-sponsored health plans from state regulations, thereby precluding the application of state parity laws. The authors estimated that nearly 49 million individuals—approximately 39 percent of the employer-sponsored health insurance market—were in self-insured plans.

In terms of public programs, Medicare does not provide parity. It requires 50 percent cost sharing by beneficiaries on essentially all outpatient mental health services as opposed to 20 percent for other outpatient services.

Medicaid meets parity requirements for children and adults, if one assumes that inpatient psychiatric care is provided in general hospitals.

In 1999 the FEHBP did not require that its participating plans meet standards for parity, but as of 2001 it did. VA and CHAMPVA health services met parity standards.

Federal Plan Changes

In 1999, 32 percent of individuals in the United States had parity in mental health benefits. An equal percentage had mental health benefits without parity. Twelve percent had benefits of unknown generosity, 7 percent had a plan whose mental health benefits were unknown, and 2 percent had health insurance with no mental health benefits. Fifteen percent of the population was uninsured (see chart on page 23).

Lurie said, "Questions of actual access for patients remain even if parity in benefits technically is provided. Strategies to manage care very frequently have followed the provision of parity in mental health benefits. Introduction of managed care means that psychiatrists receive low fees and are subjected to administrative hassles and late payments. As result, they are reluctant to accept patients whose benefits are managed."

According to the 2002 National Survey of Psychiatric Patients conducted by the American Psychiatric Institute for Research and Education's Practice Research Network, 52 percent of responding psychiatrists were not on any managed care panels *(Psychiatric News*, March 19, 2003).

Study Being Conducted

The Department of Health and Human Services and the Office of Personnel Management have funded a study to evaluate the implementation and impact of the policy directive that required participating plans of the FEHBP, as of January 2001, to provide parity in mental health and substance abuse benefits.

Research study director Howard Goldman, M.D., Ph.D., said that final results are expected this fall.

Goldman is the editor of the APA journal *Psychiatric Services* and director of mental health policy studies and a professor of psychiatry at the University of Maryland School of Medicine.

The data sources for the study included the March 2000 Current Population Survey, the 1999 Medical Expenditure Survey-Insurance Component, and the Mercer Worldwide National Survey of Employer-Sponsored Health Plans. Each survey uses a nationally representative probability sample, with 1999 serving as the reference period for each survey.

"National Estimates of Mental Health Insurance Benefits" will be posted at <www.samhsa.gov> soon. ■

Awardees

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Jack Weinberg Memorial Award for Geriatric Psychiatry: *Christopher C. Colenda, M.D., M.P.H.*, dean of the college of medicine at Texas A&M University.

Administrative Psychiatry Award Lecture: *Peter F. Buckley, M.D.*, professor and chair of the department of psychiatry and health behavior at the Medical College of Georgia in Augusta.

APA Award for Research in Psychiatry: *Jack D. Barchas, M.D.*, the Barklie McKee Henry Professor and chair of the department of psychiatry at the Weill-Cornell University Medical College and psychiatrist in chief at the Weill-Cornell Medical Center of the New York Presbyterian Hospital; *J. Christian Gillin, M.D.*, a professor of psychiatry and co-director, Lab of Sleep and Chronobiology at the University of California, San Diego School of Medicine; Gillin died in September 2003.

APA/Merck & Co. Inc. Early Academic Career Research Award: *Benjamin Flores, M.D.*, clinical instructor and staff physician in the department of psychiatry and behavioral sciences at Stanford University Medical Center; *Jan Wei Jiang, M.D.*, an assistant professor of medicine and psychiatry and behavioral sciences at Duke University Medical Center.

APIRE/AstraZeneca Young Minds in Psychiatry International Award: *Michael Breakspear, M.B.B.S., Ph.D.*, a postdoctoral research fellow at the Brain Dynamics Centre at Westmead Hospital and School of Physics at the University of Sydney; *Michael T. Compton, M.D.*, an assistant professor in the department of psychiatry and behavioral sciences at Emory University School of Medicine; *Cathryn Galanter, M.D.*, a postgraduate child psychiatry research fellow at Columbia University/New York State Psychiatric Institute; *Aysegul Yildiz, M.D.*, an assistant professor of psychiatry at Dokuz Eylul Medical School in Izmir, Turkey.

APIRE/GlaxoSmithKline Severe Mental Illness Research Fellowship: Daphne J. Holt, M.D., Ph.D., a research and clinical fellow in the department of psychiatry at Massachusetts General Hospital.

APIRE/GlaxoSmithKline Young Faculty Award for Research Development in Biological Psychiatry: *D. Jeffrey Newport, M.D.*, an assistant professor of psychiatry and behavioral sciences at the Emory University School of Medicine and associate director of the Emory Women's Mental Health Program.

APIRE/Lilly Psychiatric Research Fellowship: *Konasale M.R. Prasad, M.D.*, an assistant professor of psychiatry at Western Psychiatric Institute and Clinic at the University of Pittsburgh Medical Center; *Steven H. Snyderman, M.D.*, a research fellow and assistant instructor in the department of psychiatry at the University of Pennsylvania Health System in Philadelphia.

APIRE/Wyeth M.D./Ph.D. Psychiatric Research Fellowship: Eric Wexler, M.D., Ph.D., a research fellow at the Palo Alto VA/Stanford University.

2003 Assembly Profile of Courage Award: *Harold I. Eist, M.D.*, former APA president and private practitioner in Maryland who successfully resisted attempts by the Maryland Board of Registration in Medicine to obtain one of his patient's medical records; *Daniel S. Shrager, M.D.*, a psychiatrist in private practice in Pittsburgh who fought a court battle to keep his patient's medical records from a health insurance company.

Simon Bolivar Award Lecture: *Andres J. Pumariega, M.D.*, professor and director of child and adolescent psychiatry at East Tennessee State University in Johnson City, Tenn., and director of the university's Center of Excellence for Children in State Custody.

Solomon Carter Fuller Award Lecture: *Phyllis Harrison-Ross, M.D.*, emeritus professor of psychiatry and behavioral health services at the New York Medical College, emeritus attending psychiatrist and chief of psychiatry at Metropolitan Hospital Center in New York City, and founder and managing partner of Black Psychiatrists of Greater New York and Associates.

Alexander Gralnick, M.D., Award for Research in Schizophrenia: *Stephen R. Marder, M.D.*, director of the Department of Veterans Affairs, VISN 22 Mental Illness Research, Education, and Clinical Center, director of the section on psychosis of the UCLA Neuropsychiatric Institute, and a professor of psychiatry at the David Geffen School of Medicine at UCLA.

Manfred S. Guttmacher Award Lecture: *Margaret G. Spinelli, M.D.*, an assistant professor of clinical psychiatry at Columbia University College of Physicians and Surgeons and director of the Maternal Mental Health Program at New York State Psychiatric Institute.

Jacob K. Javits Public Service Award: *Sen. Harry Reid (D)*, the minority whip and senator from Nevada.

Judd Marmor Award Lecture: *David Spiegel, M.D.*, the Jack, Lulu, and Sam Wilson Professor of Medicine, associate chair of the department of psychiatry and behavioral sciences at Stanford University School of Medicine, director of the Psychosocial Research Laboratory, and medical director of the Stanford Center for Integrative Medicine.

Frank J. Menolascino Award for Psychiatric Services for Persons With Mental Retardation/Developmental Disabilities: *Edwin J. Mikkelsen, M.D.*, an associate professor of psychiatry at Harvard Medical School.

Adolf Meyer Award Lecture: *Glen O. Gabbard, M.D.*, Brown Foundation Chair of Psychoanalysis and a professor of psychiatry at Baylor College of Medicine in Houston, an associate editor of the *American Journal of Psychiatry*, and joint editor in chief of the *International Journal of Psychoanalysis*.

Patient Advocacy Award Lecture: *Jerilyn Ross, M.A.*, director of the Ross Center for Anxiety and Related Disorders and president and CEO of the Anxiety Disorders Association of America.

Oskar Pfister Award Lecture: *Elizabeth S. Bowman, M.D.*, a clinical professor of neurology at Indiana University School of Medicine in Indianapolis.

Benjamin Rush Award Lecture: *David Mechanic, Ph.D.*, the Rene Dubos University Professor of Behavioral Sciences and founder and director of the Institute for Health, Health Care Policy, and Aging Research at Rutgers University in New Brunswick, N.J.

Kun-Po Soo Award Lecture: *Salman Akhtar, M.D.*, a lecturer on psychiatry at Harvard Medical School and a professor of psychiatry at Jefferson Medical College.

Jeanne Spurlock, M.D., Minority Fellowship Achievement Award: *Mindy Thompson Fullilove, M.D.*, a professor of clinical psychiatry and public health at the New York State Psychiatric Institute.

Alexandra Symonds Award Lecture: *Malkah T. Notman, M.D.*, a clinical professor of psychiatry at Harvard Medical School.

George Tarjan Award Lecture: *Norma C. Panahon, M.D.*, medical director of outpatient services at the Buffalo Psychiatric Center and clinical assistant professor of psychiatry at SUNY Buffalo.

Arnold L. van Ameringen Award in Psychiatric Rehabilitation: *Jeffrey L. Geller, M.D., M.P.H.*, a professor of psychiatry at the University of Massachusetts Medical School.

APA/NIMH Vestermark Psychiatry Educator Award Lecture: *Eugene V. Beresin, M.D.*, an associate professor of psychiatry at Harvard Medical School and director of the Massachusetts General Hospital/McLean Hospital child and adolescent psychiatry residency training program. ■

Leaders

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bers believed that such a change would bring consistency to the administration of a complex and multifocused organization and allow it to fulfill its goals better. If approved, the proposal will require a change in the APA Bylaws.

• Approve the establishment of the APA Caucus on Complementary and Alternative Medicine.

• Designate a consensus statement on transcranial stimulation as a resource document (see page 24).

• Circulate a proposal for changing APA elections in which members would no longer vote for a president-elect candidate. Instead, under a "ladder plan" suggested by the APA Nominating Committee, the highest office for which members would vote would be vice president, with the winning candidate then ascending to the president-elect and then president positions. The idea behind the ladder plan is that the vice president would have an extra year to learn what the role of APA president involves and begin initiatives.

Because the committee recognized the controversial nature of the proposal, it recommended that the Board circulate it to the Assembly and to APA committees before the Board takes a final vote on the issue.

• Approved in executive session the presidential appointment of a task force to expand short- and long-term strategies to address scope-of-practice issues. The strategies will include public education, government relations, and access to psychiatric care in rural and underserved areas.

The Board also agreed to fund part of a proposal from the New Mexico district branch "involving a pilot project to enhance access to psychiatric care in rural areas." The proposal is in response to the state's psychologist-prescribing law and responds to claims that psychiatric care is not available in many areas of the state. ■

PTSD

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order and posttraumatic stress disorder and a need for some guidelines on treatment. So it probably wouldn't be inaccurate to say that that was an important factor leading to [the formation of] the work group" that developed the guideline.

The members of the work group "represented a wide range of knowledge and skills and were dedicated to both educating our APA members and helping those exposed to traumatic events," Ursano said.

Benedek noted, "The work group did the lion's share of the work in reviewing hundreds of articles and research on posttraumatic stress disorder and acute stress disorder and putting together the initial draft." The work group also got widespread input, for example, from the Steering Committee on Practice Guidelines, numerous consultants and liaisons, the APA Assembly, and APA staff.

One of the biggest challenges in developing the guideline, Benedek said, was that research data continued "to come out after the initial work and reviewing." Another problem was dealing with holes in the research. In these cases, the work group "had to try to come up with an appropriate balance of recommendations based on what research was available and that which was the result of political consensus and expert opinion.

Four other APA practice guidelines are now being worked on, Kunkle reported. They are a new guideline on obsessive-compulsive disorder and revised guidelines on psychiatric evaluation, Alzheimer's disease and other dementias of late life, and eating disorders. "We're investigating doing a guideline on aggressive behaviors," he added. "That depends on the evidence available."

Part A of the ASD and PTSD practice guideline, that is, the treatment recommendations, will be published as a supplement to the November* American Journal of Psychiatry. *The entire practice guideline will also become available at that time on APA's Web site at <www.psych.org/psych_pract/treatg/pg/prac_guide.cfm>. ■

Calculator

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company's workforce data, the costs of untreated depression, and the savings a company can reap if depressed workers are treated for their illness.

APA believes the depression calculator will be a key component of its National Partnership for Workplace Mental Health, in which it collaborates with major corporations to improve employer-supported insurance coverage for mental illness treatment (see page 4).

The depression calculator is posted online at <www.depressioncalculator.com>. Information about APA's national partnership is posted at <www.workplacementalhealth.org>. ■

Errata

The professional activity of Avram Mack, M.D., was incorrectly reported in the July 2 issue. Mack completed his fellowship in forensic psychiatry at Bellevue Hospital in New York this past year and is now a child psychiatrist in the Division of Forensic Psychiatry at the Medical University of South Carolina in Charleston, S.C.

The location of the University of Kentucky was incorrectly stated in the July 16 issue. The correct location is Lexington, Ky. ■

Psychologists

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leges. For example, psychiatrists' preparation amounts to about three years more biomedical education than clinical pharmacists with a Pharm.D., who in some states can collaboratively prescribe a limited formulary.

Psychiatrists have about three years more biomedical education than most nurse practitioners, who prescribe in all 50 states, independently in 13 states and under some physician supervision in other states.

Physician assistants average three years of biomedical education and prescribe under physician supervision in 47 states. The original graduates of the Department of Defense Psychopharmacology Demonstration Project (PDP) completed as much training as most physician assistants. Students in the first PDP class completed 24 months of didactic training prior to a 12-month clinical rotation in both inpatient and outpatient settings. The subsequent three classes of PDP students completed 12 months of didactic and 12 months of clinical work.

The average prescribing psychologist wanting to write prescriptions legally in New Mexico or Louisiana will have on average completed the equivalent of one year of postdoctoral biomedical education when he or she begins prescriptive practice.

At least seven programs offer psychopharmacological training to psychologists. Using information available on the Internet, including the Web site of the American Psychological Association, *Psychiatric News* compared the available programs.

Many of the programs might be considered more rigorous than the original model curriculum—all programs meet the higher standard of a minimum of 450 hours of instruction set by both the New Mexico and Louisiana laws. The number of psychologists who have completed psychopharmacology training programs is reported to be in excess of 1,000, according to the American Psychological Association.

Just how well trained psychologists are in psychopharmacology depends upon which program they choose to complete (see table on facing page).

Four programs offer curricula culminating in the award of a postdoctoral master of science in clinical psychopharmacology.

The first degree program in clinical psychopharmacology was developed in 1998 by the California School of Professional Psychology in collaboration with Alliant International University in Alameda, Calif. At a cost just under $10,000, the Alliant program includes 450 contact hours (432 in "direct classroom instruction" and 18 in home study), offering 28.8 academic credits. The catalog notes, however, that "students living over 100 miles from a teaching site can attend through audio conference call using class handouts and videotapes of classes." This "flex-plan" option requires students to attend at least eight weekends a year on site.

The Alliant catalog also notes that the program is offered at the level of a master's degree for two main reasons: to ensure students will "receive a credential that accurately reflects the level of rigor and the intensive nature of the training that they have completed," and graduates will be interacting with other prescribing professionals, and as such, "an academic degree requiring examinations in each course is appropriate."

Exams in each of the four degree programs are generally multiple choice and may be taken again if failed, and all course work is graded on a pass-fail system. The Alliant program has to date graduated "more than 200 psychologists in six states," and "40 more will graduate in 2004," according to the 2004-05 catalog.

The other degree-granting programs are similar to those of Alliant, with a few differences. Fairleigh Dickinson University (FDU) in New Jersey offers a slightly heavier program at 480 contact hours offering 30 credits. Though the bulk of the curriculum is delivered through a distance format, students meet five weekends during the training program.

Students who graduate from the program may elect to take a clinical practicum if they "desire to practice the management of psychopharmacotherapy in a supervised setting." During this time they are exposed to the minimum 100 patients required in both the model curriculum and the two state statutes. The FDU catalog emphasizes that the program is different from others "in the degree to which both clinical and didactic instruction are emphasized." It goes on to say that each student will have available not only the course instructor, but also "a facilitator, who is a practicing clinician involved in prescriptive practice. In most cases the facilitators have been nurse practitioners, although some have been physicians."

Significantly, the FDU catalog notes that the program does not meet some aspects of the model curriculum, in particular, "practicum placement in both inpatient and outpatient settings. To our knowledge, no program in the country has so far been able to meet these criteria. We will comply with

Passing a National Exam Required

Regardless of which educational program psychologists choose to complete, they will not be able to prescribe legally in New Mexico or Louisiana unless they take a national certification exam.

The only exam available is the Psychopharmacology Examination for Psychologists (PEP), developed by the American Psychological Association's College of Professional Psychology. The PEP was "primarily developed to be made available for use by state and provincial psychology licensing authorities when they set requirements to implement newly enacted laws," according to the exam's brochure, available online.

To take the exam, candidates must have a doctoral degree in psychology, possess a license in good standing, and have successfully completed a "postdoctoral program of education in an organized program of intensive didactic instruction."

The PEP is administered on computer at Sylvan Technology Centers across the country. Candidates have three hours in which to complete 150 multiple-choice questions. If a candidate's score falls below "the recommended passing score"—the psychological association would not confirm for *Psychiatric News* what the passing score is—then the exam may be taken a second time after a 90-day wait. Candidates who fail the second time must wait a year to retake the exam.

The fees for the exam as of June 30 included a $200 examination fee and an application fee of $325 for psychological association members or $395 for nonmembers.

these requirements as they become more feasible."

The program at the Massachusetts School of Professional Psychology (MSPP) offers an on-site program of courses on Fridays and Saturdays for 30 weekends over two academic years. For the 2004-05 academic year MSPP will offer an online program, which requires attendance on campus at nine specific weekends over the two academic years. The MSPP program also offers a track for advanced nurses who wish to learn psychopharmacology.

Differing from the other three degree programs, Nova Southeastern University's Center for Psychological Studies (Nova) program is offered as a campus-based, graduate-degree program as well as a "fly-in" program configured as five six-day extended weekends when students come to the Fort Lauderdale campus for classes Thursday through Tuesday, 9 a.m. to 5 p.m. The program is augmented by significant online resources. All candidates for the degree must complete requirements within five academic years.

Of the four degree programs, Nova places the most emphasis on the practicum. The Nova program requires two "100-hour, intensively supervised clinical experiences, ordinarily scheduled in the summer terms, where a minimum of 50 patients is seen during each practicum."

The program catalog emphasizes that students should spend 100 hours or more with a mentor who is "qualified"—"a boarded psychiatrist or an otherwise equally qualified medical practitioner."

Undoubtedly, as more states grant prescriptive authority to psychologists, more programs will develop, most likely in the model of the postdoctoral master's degree formats outlined in the New Mexico and Louisiana statutes.

In New Mexico, the Southwestern Institute for the Advancement of Psychotherapy is collaborating with the New Mexico State University (NMSU) and offers professional development credits on an NMSU transcript. The program is seeking degree-awarding authority.

Two certificate programs also are available. The Prescribing Psychologists' Register in Miami offers a distance-learning model of either just over 300 hours or the 450 needed to meet the current statutes. To complete the certificate, the candidate must complete a practicum involving 100 patients under a physician preceptor.

The Psychopharmacology Institute, based in Lincoln, Neb., offers an entirely online certificate program composed of 496 hours; its credits are "transferable to two regionally accredited institutions for a postdoctoral master's degree in psychopharmacology."

Regardless of which program a psychologist chooses, none is the equivalent of a medical school education. Indeed, one program includes in the course description for the first course in its curriculum the topic "Why psychologists will never become 'mini-psychiatrists.' " ■

Professional News

Foundation Announces New Donor Clubs

The American Psychiatric Foundation is unveiling a new donor club program to honors its outstanding supporters and to offer new, enhanced benefits for donors.

"We hope to attract new interest through this program while making sure that our present supporters know how much we value them," said the foundation's president, Altha J. Stewart, MD.

The foundation's current donor club program features the prestigious Benjamin Rush Circle for lifetime donors of $10,000. The new program includes the addition of the Foundation Circle to honor lifetime contributors of $25,000 and newly named annual giving levels including the Platinum Circle ($2,500), the Gold Circle ($1,000), and the Silver Circle ($500).

Each donor will receive recognition in the foundation's publications and a lapel pin. In addition, Foundation Circle, Benjamin Rush Circle, and Platinum Circle members receive two complimentary tickets to the foundation's annual benefit and an invitation to a special reception at the APA's annual meeting. Gold Circle members also receive an invitation to this special reception.

"Undoubtedly, the major benefit of contributing to the foundation is knowing that your generosity will fund grants and programs educating the public about mental illness and the availability of treatment," said Stewart.

More information about the foundation's donor clubs can be obtained online by visiting <www.psychfoundation.org/giving/index.cfm> or by calling (703) 907-8519. ■

Association News

Nominations Invited for Irma Bland Award

APA's Council on Medical Education and Lifelong Learning seeks nominations for the Irma Bland Award for Excellence in Teaching Residents. This award gives certificates to APA members who have made outstanding and sustaining contributions to resident education in psychiatry.

Nominees should have significant and sustained contributions (at least three years of teaching at the nominating institution) to the advancement of resident education in one or more of the following categories: teaching in different settings (psychiatry emergency services, inpatient, outpatient, community mental health, and other subspecialty settings); lectures/didactics; small group teaching or rounds; supervision; course design and/or administration; departmental committees (curriculum, evaluation, and promotions); institutional committees (admissions, curriculum, student affairs, and promotions); career counseling; research, publications, and/or presentations; and extracurricular programs (for example, orientation and leading support groups).

The council will select one salaried faculty member (any faculty member paid by the residency program, affiliated hospital, or any other source for time spent teaching residents) and one voluntary faculty member (any faculty member not paid by the residency program, affiliated hospital, or any other source for time spent teaching residents) for each general psychiatry training program.

General psychiatry residency training programs accredited by the Accreditation Council for Graduate Medical Education and the Royal College of Psychiatrists are eligible to nominate faculty.

The nomination deadline is November 1. More information and a nomination form are posted online at <www.psych.org/edu/blandaward.cfm>. ■

Arts

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Second: "Face I," Andrew Lauronilla, M.D.
Third: "Chosen People's Box," William A. Alvarez, M.D.

Glass
First: "Blue Bowl," Habib Nathan, M.D.
Second: "Hand," Habib Nathan, M.D.
Third: "Angel," Habib Nathan, M.D.

Graphics
First: "Melancholia," Jeffrey Delisle, M.D.
Second: "Life Support," Jeffrey Delisle, M.D.
Third: "Juggler," Caroline Choo, M.D., Paula Stromberg

Photography—Color
First: "Skultura Comienda Gatorum," Sonia Pawluczyk, M.D.
Second: "Patagonia Gaucho I," Sonia Pawluczyk, M.D.
Third: "Flowing Serenity," Sonia Pawluczyk, M.D.

Photography—Black and White
First: "Uncle Tom's Bridge," Donald Ottenstein, M.D.
Second: "Curious Pug," Victoria Kelly, M.D.
Third: "Hip Hop Dancers," Ira Glick, M.D.

Mixed Media
First: "When We Said Goodbye," Caroline Choo, M.D., Paula Stromberg
Second: "Granada/Alhambra," Astrid Rusquellas, M.D.
Third: "San Telmo," Astrid Rusquellas, M.D.

Painting—Oil
First: "Chicago Desert," Cristel Lempke
Second: "The Guirson Bush," Dolores Brachman; "Meditation," Priyani De Silva, M.D.; "Provena," Dolores Brachman
Third: "Autumn," Manije Nathan

Painting—Watercolor
First: "Lighthouse," Priyani De Silva, M.D.
Second: "Fishing Boat," Aydogan Ugur, M.D.; "Mirror," Astrid Rusquellas, M.D.; "The Centinel," Dolores Brachman
Third: "Reflection," Astrid Rusquellas, M.D.

Painting—Acrylic
First: "Ed's Barber Shop," Jeffrey Delisle, M.D.
Second: "Acrophilia," Jeffrey Delisle, M.D.
Third: "Alhambra Albaicin," Astrid Rusquellas, M.D.

Other
First: "Substance-Induced Mood Disorder" (pastel), Wilma Rosen, M.D.
Second: "Beneath the Surface" (water color tissue collage), Karen Jaegerman Collins
Third: "Impetuous" (water color tissue collage), Karen Jaegerman Collins

Sculpture
First: "Tango For Ever," Astrid Rusquellas, M.D.
Second: Untitled, S.R. Bortner, M.D.
Third: "Abstract in Yew," Roy Fitzgerald, M.D. ■