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PSYCHIATRIC NEWS

"See" references appear as follows:

48 - 1
13 -12
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Photo: Maureen Keating

Peter Jensen, M.D., addresses lawmakers at a Capitol Hill luncheon sponsored by APA and the National Alliance for the Mentally Ill. "Everybody is saying we've got to do a better job identifying kids with mental health needs," he said. "Well, we know what to do, but we aren't able to do it." See story on page 20. He made his remarks in September as psychiatrists awaited the FDA decision regarding a black-box warning for pediatric use of antidepressants.

Government News

FDA Issues Controversial Black-Box Warning

Despite the concerns of APA and other groups, the FDA issues strongly worded warnings directly linking antidepressants and increased suicidal thoughts and behaviors.

BY JIM ROSACK

October 15, 2004, quickly became known by some as "black Friday"—the day on which the Food and Drug Administration (FDA) ordered drug companies to label all antidepressant medications distributed in the United States with strongly worded warnings that the medications "increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with major depressive disorder (MDD) or other psychiatric disorders."

The FDA's language within the new black-box warning and the additional information that drug makers will have to add to the "WARNINGS—Clinical Worsening and Suicide Risk" section of the drugs' labels is indeed strong, leaving no doubt that the agency believes there is a direct causal link between the 32 antidepressant medications currently marketed (see list on page 48) and increased suicidal thoughts and behaviors (see text of black-box warning on page 48.)

The black box urges families and caregivers, as well as clinicians, to observe patients closely for "clinical worsening, suicidality, or unusual changes in behavior" associated with the initiation of antidepressant therapy. Within the expanded "warnings" section, the label explains "unusual changes in behavior" further, adding "anxiety, agitation, panic attacks, insomnia, irritability, hostility (aggressiveness), impulsivity, akathisia (psychomotor restlessness), hypomania, and mania have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric."

The labeling then states that "although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality."

Although the FDA acknowledges no causal link in the above statement, the agency nonetheless says at the beginning of the new "Warnings" section, "A causal role for antidepressants in inducing suicidality has been established in pediatric patients." The labeling does not explain this seemingly contradictory language.

The new labeling dictates that patients being treated with the drugs "for any indication" should be closely watched. "Ideally," the new labeling states, "such observation would include at least weekly face-to-face contact with patients or their family members or caregivers during the first 4 weeks of treatment, then biweekly visits for the next 4 weeks, then at 12 weeks, and as clinically

please see ***Warning*** *on page 48*

International News

Iraq Desperate To Rebuild Shattered Health System

Iraq's new health minister faces enormous challenges in modernizing the system. Meanwhile, hospitals in Baghdad face inadequate security, power, and supplies, a prominent Iraqi doctor tells a medical coalition for Iraq.

BY CHRISTINE LEHMANN

A two-day conference on Iraqi health care at APA headquarters in late September drew more than 40 physicians from U.S. medical specialty societies including several Iraqi-American physicians and representatives of the Iraqi Society of Physicians, Iraqi Medical Sciences Association, AMA, British Medical Association, and World Medical Association.

APA member Col. E. Cameron Ritchie, M.C., the psychiatric consultant to the Army surgeon general, was a co-organizer of the conference at APA. "We wanted to show our support for our Iraqi colleagues and get an update on the health care situation there including government and nongovernment sponsored health care initiatives."

Ritchie added, "I am pleased that APA leadership continues to support professional exchanges with Iraqi physicians. In addition to hosting this conference, the president's [Marcia Goin, M.D.] symposium in May was devoted to rebuilding health care systems emerging from conflict such as Iraq, and Marcia Goin, Jay Scully, Darrel Regier, and I participated in a July 2003 conference devoted to rehabilitating Iraq's psychiatric services sponsored by the World Health Organization and the World Psychiatric Association in Cairo."

Michael Brennan, M.D., of the Ameri-

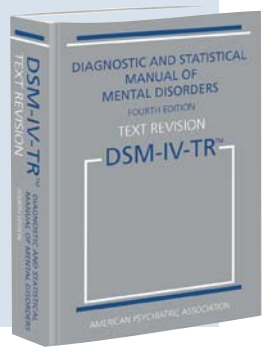
please see ***Iraq*** *on page 18*

Professional News

Notice to All Practitioners

Important Diagnostic Coding Change

Because of changes made to *ICD-9-CM* effective October 1, the diagnostic code for narcolepsy is now 347.00 (instead of 347). Please change your copy of *DSM-IV-TR* accordingly.



APA Committee Strives to Recruit Native Americans to Psychiatry

APA figures prominently in the battle to bring culturally competent mental health care to Native Americans, who have higher rates of some mental illnesses than the general population.

BY EVE BENDER

By reaching out to Native-American college students, medical students, and psychiatry residents, APA is hoping to add more diversity to the psychiatric workforce and call attention to the need for improved mental health services in Native-American communities.

"We must educate Native Americans about major mental illnesses and the impact they have on our communities," said Frank Brown, M.D., chair of APA's Committee of American Indian, Alaska Native, and Native Hawaiian Psychiatrists and an associate professor of psychiatry and behavioral sciences at Emory University.

Frank Brown, M.D., is fighting for greater inclusion of Native Americans in the psychiatric workforce. He is chair of APA's Committee of American Indian, Alaska Native, and Native Hawaiian Psychiatrists.

Brown, who is of Cherokee descent, appeared at the 2004 Indian Health Summit in Washington, D.C., in September.

The summit was held by the Indian Health Service (IHS), an agency of the Department of Health and Human Services that is responsible for providing federal health services to Native Americans and Alaska Natives. The meeting coincided with the opening of the National Museum of the American Indian in Washington, D.C.

According to data from the Substance Abuse and Mental Health Services Administration, American-Indian men aged 25 to 34 are twice as likely to commit suicide as their non-Indian counterparts.

"We must continue to be aggressive about suicide prevention in this population," Brown said.

He pointed out that "depression knows no boundaries" and emphasized the need to teach Native Americans that depression is "common, treatable, and does not imply a weakness in character."

In addition, Brown underscored the importance of preventing the early onset of alcohol and drug abuse in Native Americans, who have been found to be as much as seven times more likely to have alcohol-related problems as those in the general population.

Brown also addressed the need to recruit Native Americans into the psychiatric workforce.

He estimated that there are only about 50 Native-American psychiatrists, 37 of whom identify themselves as Native American.

"The goal is to increase the number of culturally sensitive trained psychiatrists out there to care for the Native-American population. One way to do this is to have Native Americans working with Native Americans," he declared.

Members of APA's Committee of American Indian, Alaska Native, and Native Hawaiian Psychiatrists are working toward this goal by reaching out to Native-American college students to encourage them to pursue careers in medicine, and with Native-American medical students to spark an interest in the field of psychiatry, Brown said.

"We also work with Native-American psychiatry residents to establish mentorships and foster their growth and development within the field," Brown noted.

Part of the committee's work involves linking psychiatry residents with IHS staff and Native-American physicians already working on Indian reservations, he added.

APA is also collaborating with the Association of American Indian Physicians, an Oklahoma-based organization that recruits Native Americans into medicine and provides support for Native-American physicians in the United States.

At the organization's annual conference, APA provides Native-American medical students with "in-depth information about the practice of psychiatry, APA, and psychiatric disease processes in Native Americans," Brown said.

He also noted that Native-American subjects have historically been left out of medical research, and inclusion is necessary to "show the disproportionate rates of illness among Native Americans and the disparities in funding for diagnosis, prevention, and treatment of disease in this population."

Information about medical and health-related programs of the Indian Health Service is posted online at <www.ihs.gov>. ■

Task Force Appointed to Address Psychologist-Prescribing Issues

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

APA is committed to putting an end to psychologists' bid to win prescription privileges throughout the United States, and as part of a strategy to focus that commitment, the Board of Trustees agreed with me at our June retreat to create a special component called the Presidential Task Force to Review the Psychologist Prescribing Issue.

At the time of the retreat, Louisiana had just passed a psychologist-prescribing law—the second in the nation—and we anticipated that 2005 would see a flurry of similar legislation in several states. We resolved that such a law should not pass elsewhere.

Members of other medical specialties told us at our retreat that psychiatry is not alone in confronting assaults on safe patient care and that, to date, APA has done laudable work to halt attempts by psychologists to gain prescribing rights. But they also confirmed our forecast for 2005: With two state victories behind them, psychologists will fight for prescribing privileges in even more states.

The Board recognized that a task force would be a key step toward reinforcing and intensifying APA's advocacy on scope-of-practice and related patient safety issues—top priorities for us then, now, and in 2005 and beyond. And so the Presidential Task Force to Review the Psychologist Prescribing Issue was formed.

The task force has been charged with providing the Board with comprehensive short- and long-range strategies to address our scope-of-practice and patient safety concerns, and it will provide a report to the Board in December. These are the members of the task force:

• **Chair: Allan Tasman, M.D., of Kentucky.** Dr. Tasman is a past president of APA (1999-2000) and serves as chair of the Executive and Officer Compensation Committee, a member of the Finance and Budget Committee, and a member of the Council on Global Psychiatry. Dr. Tasman has held several other leadership roles in APA components, the World Psychiatric Association, and other prominent organizations.

• **Harold Eist, M.D., of Maryland.** Dr. Eist is a past president of APA (1996-97) and, among other leadership positions, recently chaired the Council on Global Psychiatry. He also served twice as president of the Washington Psychiatric Society.

• **Barbara Gard of California.** Ms. Gard is the executive director of the California Psychiatric Association (CPA) and has provided much experience and thoughtful leadership to CPA regarding psychologists' prescribing attempts in California.

• **Patrice Harris, M.D., of Georgia.** Dr. Harris serves on several APA components, including as an alternate in the APA delegation to the AMA and as an APA*PAC* board member. Dr. Harris is vice president of the Georgia Psychiatric Physicians Association and a past trustee-at-large of APA.

• **Karen Lynne Moritz, M.D., of Missouri.** Dr. Moritz has served in the APA delegation to the AMA and on the Committee on Private Practice. She also served as legislative representative for Eastern Missouri Psychiatric Society.

• **Rodrigo Muñoz, M.D., of California.** Dr. Muñoz is a past president of APA (1998-99) and chairs the Council on Global Psychiatry. He also serves in the APA delegation to the AMA and has held other leadership posts.

• **Robert Pyles, M.D., of Massachusetts.** Dr. Pyles represents the Massachusetts Psychiatric Society in the APA Assembly. He also served on the Joint Commission on Government Relations, a former APA component whose responsibilities now fall under the Council on Advocacy and Public Policy.

The task force, as you may have already heard through other communication channels, is seeking your advice and consultation. Dr. Tasman and his team are interested in knowing what—in addition to the hard work that APA has already done—you think must be done locally and nationally, the resources it will take, and your ideas about strategy, both short and long term. Please e-mail your confidential comments to Dr. Tasman at atasman@psych.org or write to him at this address: Allan Tasman, M.D., Professor and Chair, Department of Psychiatry and Behavioral Sciences, University of Louisville School of Medicine, Louisville, Ky. 40292.

As I wrote in this space before, fighting to protect our patients "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."

All of this is to underscore that we need your help, input, and support at this critical time. Psychologists are determined, and—for our patients' sake—we must be determined more so.

APA is committed to maintaining and improving the quality of care our patients receive. With your help, the task force—along with the Board, the Assembly, the staff, and indeed, the entire Association—will succeed in positioning APA for victory for our patients in 2005 and beyond. ■

Erratum

The "From the President" column in the October 1 *Psychiatric News* incorrectly reported data on suicidal ideation and attempts in a community sample of youth and adolescents. The article should have stated, "Of those reporting lifetime suicide attempts, 37.5 percent had a diagnosis of major depressive disorder, and of those reporting suicidal ideation, 23.3 percent were diagnosed with major depressive disorder." ■

APA Marshals Resources To Fight Formulary Proposal

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

Psychiatric News reports on page 24 about APA's extensive, detailed comments on the federal government's draft rules to implement the Medicare Modernization Act (MMA), the law that establishes a new Medicare prescription drug benefit. APA members wishing to read or download our comments will find them posted online at <www.psych.org/advocacy_policy/reg_comments/cms-4086.pdf>.

The rules implementing the Medicare drug benefit could have a profound impact on our patients, particularly very vulnerable, low-income beneficiaries (so-called "dual eligibles") who receive drug coverage through state Medicaid programs but will be shifted into the new Medicare benefit. Chief among our many concerns is that the proposed guidelines that participating health plans will have to follow for developing their respective formularies overly restrict access to psychotropic medications.

I hope you will take the time to read APA's extensive comments. They lay out in a clear and compelling way what we as psychiatrists know intuitively—that our patients need access to the full range of available medications and therapies to ensure that they receive state-of-the-art treatment. Nearly 40 percent of dual eligibles, for example, have cognitive or mental impairments; thus, the consequences of abrupt medication switching (or discontinuation) could be dire. Fortunately, most state Medicaid programs recognize the problem. Of the 40 states that have established preferred drug lists or formularies, 30 have included exemptions for psychiatric medications.

Without changes, these are among the likely consequences of the currently envisioned MMA rules:

- Putting vulnerable psychiatric patients at risk for bad health outcomes.
- Disrupting the continuity of care for psychiatric patients who, as part of their current Medicaid coverage, are now successfully being treated with a medication that may not be covered by the new Medicare drug benefit.
- Increasing overall costs to Medicare due to increased emergency room visits and inpatient hospitalizations.

As a result of our concern for the well-being of our patients, we are calling for the establishment of an alternative formulary—one that is the least restrictive possible. This alternative formulary would be for a class of enrollees who have a primary diagnosis as defined by *DSM-IV-TR* and for whom a physician has determined that it is medically necessary to treat their medical condition pharmacologically. This formulary would provide access to the full array of psychiatric medications for individuals with mental illness diagnoses, including dual-eligible beneficiaries, without such restrictive policies as fail first, prior authorization, step therapy, and therapeutic substitution.

As comprehensive as our comments are, they are one endpoint in a tremendous internal and external APA effort that is often hidden from the view of most members. The foundation for the case for an alternative formulary was created by the National Alliance for the Mentally Ill working in concert with APA's Department of Government Relations (DGR) and others, in report language adopted when the law was enacted that acknowledged the urgent need for attention to our patients. The comments themselves represent the outstanding work of the Office of Healthcare Systems and Financing and DGR.

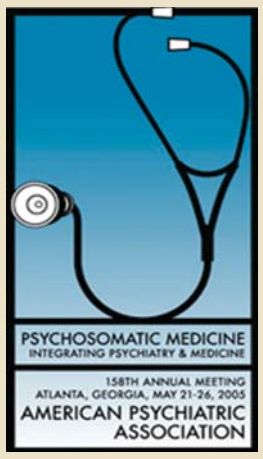
It is not sufficient to argue policy in such comments. To have maximum impact, the comments have to make the case based on the law's intent. Here, Sam Muszynski, Andy Whitman, Becky Yowell, and other staff members have done a great job in making the scientific, medical, and legal case for our proposed alternative formulary.

That is only the tip of the current effort. APA has long been working in a coalition with patient groups and others concerned about the impact of the law. We have held meetings with key officials from the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services to preview our concerns. We have presented testimony to the group responsible for recommending technical details about how a formulary would work. Our government relations staff have arranged for meetings with key House and Senate committee staff (both Republicans and Democrats) to ensure that Congress understands the consequences of a poorly thought-out drug benefit for our patients. Working behind the scenes, DGR staff helped ensure that key members of Congress asked tough questions of officials responsible for implementing the law. And you—our members—responded magnificently to our request that you send your own supporting comments directly to CMS.

When I joined APA as your medical director, I assigned a high priority to getting our dedicated staff to work better together. It is human nature in any bureaucracy (and APA is a bureaucracy, too) to focus on the pressing priorities confronting your own "silo." Our division and department directors are working to break down their silos to ensure that APA is responding effectively to urgent priorities by utilizing the expertise of our entire organization. The team-oriented approach to the MMA and other issues, such as our coordinated response to the struggle to ensure continued access to antidepressants for children and adolescents, is yielding important dividends to APA, our members, and—more importantly—our patients.

Please send your comments to me at medicaldirector@psych.org. ■

Priority Hotel Reservations for APA Members



During December, APA members will have an exclusive opportunity to make their hotel reservations for the 2005 annual meeting in Atlanta.

To obtain more information about the meeting and participating hotels, go to APA's Web site at <www. psych.org>. After logging into Members Corner, click on "2005 Annual Meeting." If work or travel plans change, you can update or cancel your reservations at this site.

To make the process as simple as possible, you may register in the following ways:

- **Online:** <www.psych.org>. Click on "Members Corner" and log in, and then click on "2005 Annual Meeting" and follow housing link to Travel Planners Inc.
- **By Phone:** (800) 221-3531 or (212) 532-1660. Lines are open Monday through Friday from 9 a.m. to 7 p.m. Eastern time.
- **By Fax.** (212) 779-6128.
- **By Mail:** Travel Planners Inc., 381 Park Avenue South, Third Floor, New York, N.Y. 10016.

Your membership number is needed to make advance hotel reservations. Reservations made by mail will be accepted with payment by credit card or check made payable to Travel Planners Inc. The deadline for hotel reservations is April 22, 2005, although call-in reservations will be accepted after that date based on availability. All cancellations must be made through Travel Planners before April 22, 2005.

Depressed Workers on the Job Hurt the Bottom Line

Major depression diminishes work performance in terms of both productivity and task focus, resulting in workers missing the equivalent of 2.3 days a month.

BY MARK MORAN

Lost productivity due only to employee absenteeism may underestimate the true effect of depression on people's work lives.

A study in the October *American Journal of Psychiatry* suggests that diminished productivity while workers are on the job—what has been called "presenteeism"—may significantly add to the costs attributable to untreated or inadequately treated depression.

Moreover, compared with other conditions that significantly impact on-the-job productivity, depression appears to be among the most debilitating, according to the study.

Lead study author Phillip Wang, M.D., M.P.H., explained that surveyed workers were asked a series of questions that together measured two outcome variables: overall productivity and "task focus," or the degree to which workers were able to focus diligently on a work task at hand.

"The most important finding is the consistency with which depression is associated with negative measures on both productivity and task focus," Wang told *Psychiatric News*. "Previous studies have shown that the amount of work lost to depression just looking at absenteeism is about one day a month. Our study found that presenteeism accounts for a total of about 2.3 lost work days a month. So it appears that the productivity lost by depressed people at work may be larger than that lost from absenteeism."

> **"The message for clinicians is that there are benefits to treating depression adequately that go beyond the clinical outcome."**

Wang is an assistant professor of medicine, epidemiology, and health care policy at Harvard Medical School.

The study makes use of a design known as "experience sampling" to capture work productivity at discrete moments in time while workers are at their jobs. Though the experience sampling method (ESM) has some limitations—among them that the consistency of estimates with real-life work performance is difficult to gauge—it avoids the recall bias inherent in standard self-reporting measures that require workers to remember their on-the-job performance.

The study was part of a larger survey of health and productivity conducted by the World Health Organization of two types of service workers: reservation agents working for a major airline and customer-service representatives working for a major telecommunications company. A subsample of 105 reservation agents and 181 customer-service representatives was taken from the larger survey, with deliberate oversampling of respondents who reported either major depression or any of several other chronic conditions.

Participants were given a beeper and diaries in which they were to make entries about moment-in-time experiences at five randomly paged moments each day over seven consecutive days.

At each of the paged moments, participants recorded answers to questions using a seven-point scale designed to assess their performance. Independent effects on work-related performance were then compared across seven chronic conditions, using statistical analysis to account for co-occurrence of conditions.

The seven conditions were allergies, arthritis, asthma, back pain, headaches, high blood pressure, and major depression.

Results showed that major depression was the only condition significantly related to diminished performance in both productivity and task focus. The effects were equivalent to approximately 2.3 days absent per depressed worker a month.

In the category of task focus, depression was substantially more debilitating than the other six conditions. In the category of productivity, only back pain was more debilitating, according to the study.

Using the estimated 2.3 days a month of missed work due to presenteeism, and the one day a month lost to absenteeism found in previous studies, the researchers then calculated the combined salary-equivalent effect of major depression on absenteeism and lost productivity to be greater than $300 a month.

"The message for clinicians is that there are benefits to treating depression adequately that go beyond the clinical outcome," Wang told *Psychiatric News*.

But Wang said there is also a message for employers and purchasers of health care, noting that he is involved in a large trial to see how much work productivity can be recovered if employers provide health insurance that offers excellent coverage for treatment of depression.

"The employer who purchases adequate treatment of depression might actually see a return on investment," he said.

The study, "Effects of Major Depression on Moment-in-Time Work Performance," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/10/1885?>. ■

WYETH EFFEXOR

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Cultural Sensitivity Called Key Element of Quality Care

Michelle Riba, M.D., draws special attention to a project designed to raise the national profile of APA in efforts to reduce or eliminate health care disparities.

BY MARK MORAN

Culture counts in the diagnosis and treatment of mental illness. And culture is a critical factor in widely documented disparities in access to, and quality of, medical care for racial and ethnic minorities in the United States, said APA President Michelle Riba, M.D., in her opening address at APA's 56th Institute on Psychiatric Services last month in Atlanta.

"The culture that patients come from shapes their mental health and the type of services they use," Riba said. "Likewise, the culture of the clinician and the service system affects diagnosis and treatment and the organization and financing of those services. Cultural differences must be accounted for to ensure that minorities, like all Americans, receive mental health care tailored to their needs."

This year's institute, whose theme was "Mental Health Disparities in the Community," included lectures and symposia on Hispanic-American perspectives on mental health care; race, substance abuse, and bipolar disorder; psychoanalysis and Eastern cultures; and disparities in children's mental health.

In her opening speech, Riba gave a broad overview of how disparities affect individual patient care at the community level and outlined how advances in psychosomatic medicine—a special interest of Riba's—may contribute to reducing and eliminating racial and ethnic disparities in mental health care.

She also cited specific areas in which APA, through its Department of Minority and National Affairs, is seeking to address the issue of health care disparities.

The APA president cited chronic underfunding of public health systems—in which racial and ethnic minorities disproportionately receive medical care—as one essential factor in the disparities in quality and access to care.

Photo: Ellen Dallager

APA President Michelle Riba, M.D., performs the traditional bell-ringing ceremony that opens each Institute on Psychiatric Services.

"Over the years, many states have faced major financial crises that are having a ripple effect on mental health services at the community level," she said. "As states take drastic measures to control growth in Medicaid expenditures, mental health care funding becomes ever more vulnerable. Community mental health systems have grown increasingly dependent on Medicaid with more than 60 percent of monies for public mental health services funded by Medicaid.

"Since minorities are major users of public health systems, access to quality care is often encumbered by lack of quality services and lack of cultural competency in treating diverse patients."

Riba said advances in psychosomatic medicine and the recent approval of psychosomatic medicine as a subspecialty by the Accreditation Council for Graduate Medical Education (ACGME) have positive implications for all Americans, but may prove especially helpful in reducing mental health disparities.

Many patients in the public health system suffer from both psychiatric and other types of medical problems, Riba said. "Heart disease and stroke are leading causes of death for all racial and ethnic groups, and these conditions are often compounded by depression and substance abuse."

She cited especially the work of APA's Council on Psychosomatic Medicine in seeking support for access to care and reimbursement for treatment of psychosomatic conditions.

Finally, Riba cited areas in which advances are being made to address racial and ethnic disparities in health care, including mental health care. At the academic level, she said, the ACGME has required training programs to provide supervised experience treating patients throughout the life cycle and from diverse cultural backgrounds.

Particularly important, Riba said, is the need to increase the proportion of underrepresented racial and ethnic minorities among the health professions. "We have an opportunity as a profession to make a difference through the recruitment of more minority medical students and through culturally competent education and research," she said.

please see ***Cultural Sensitivity*** *on page 46*

ASTRAZENECA SEROQUEL
(DELIVERY)
P4C

Stalkers Inhabit a Reality All Their Own

Stalkers' fantasies are deeply rooted and nearly intransigent—whether they are seeking intimacy, plotting revenge, pursuing pathological romantic infatuations, or acting out predatory desires.

BY MARK MORAN

Resentful, delusional, predatory, or pathologically infatuated—stalkers of the famous and the powerful live in a world of their own.

And they have been recognized long enough that forensic specialists have developed a unique nomenclature to classify the types of individuals who obsessively follow, intrude upon, and sometimes take the lives of the celebrated, said Robert T.M. Phillips, M.D., Ph.D., president-elect of the American Academy of Psychiatry and the Law.

Phillips presented a broad overview of the colorful, if disturbing, history of celebrity stalkers and presidential assassins at APA's 56th Institute on Psychiatric Services last month in Atlanta.

While describing in detail the unique quirks and idiosyncratic fantasies of stalkers over the years, he outlined a specialized system of classification to encompass them all.

"It is important to recognize that celebrity stalkers don't fit neatly into existing typologies," Phillips said. "When you attempt to categorize the unique behaviors manifested by those who persistently follow and intrude upon the lives of the famous, a slight modification of nomenclature is necessary."

He is an adjunct associate professor of psychiatry at the University of Maryland schools of medicine and law, Baltimore, and serves as a consultant to the Protective Intelligence Division of the United States Secret Service. He is a member of the AMA House of Delegates and a former deputy medical director of APA.

Contact With Target Unwelcome

Stalking itself is relatively straightforward, involving actions that are unwelcome and intrusive to—and induce fear and concern in—a "target" individual. Such actions can include following, loitering, and approaching the target repeatedly; they can also include such technological intrusions as repeated telephoning, faxing, or e-mailing.

"Any way in which an individual can make an unwelcome contact with the target can form the foundation for a legal case of stalking," Phillips said.

Drawing on terminology developed by Paul Mullen, M.B., D.Sc, of the Victorian Forensic Psychiatry Services in Australia, Phillips examined a long line of celebrity and presidential stalkers, sorting them into one of several categories: pathologically infatuated stalkers, predatory stalkers, intimacy seekers, and rejected stalkers.

John Hinckley, morbidly obsessed with movie star Jodie Foster, is perhaps the most famous example of the pathologically infatuated celebrity stalker. Phillips described how Hinckley's fascination with Foster long predated his 1981 shooting of President Ronald Reagan and persisted even as Hinckley was engaged in long-term psychotherapeutic treatment.

"It is not uncommon for individuals to be engaged in these [obsessive stalking] activities while they are engaged in long, well-developed therapeutic relationships," said Phillips. "The issue simply never comes up. They are very, very good at making sure that information is contained."

Somewhat less well known are the predatory stalkers William Tagger, who assaulted newsman Dan Rather and later murdered an NBC employee, and Jonathan Norman, who stalked filmmaker Steven Spielberg.

Reciprocated Love Sought

Intimacy seekers are those possessed of a delusion of reciprocated love, and they have not always required the incessant spotlight of television to fuel their morbid fascination—a fact made evident in the case of Ruth Ann Steinhagen, who in 1949 shot Philadelphia Phillies first baseman Eddie Waitkus. It was Waitkus who inspired the movie "The Natural," starring Robert Redford.

Phillips described how Steinhagen, of Chicago, first saw Waitkus on the field when he played for the Chicago Cubs. She became romantically obsessed with him and papered her room with clippings and pictures of the ballplayer. Frequently, she set a place for him at the family dinner table, Phillips said.

In 1949 Waitkus was traded to Philadelphia, which "upset" Steinhagen, Phillips said. When she learned that the Philadelphia team would be in Chicago in June of that year, she made reservations at the Edgewater Hotel under an assumed name.

"On the 14th she went to the game, then went back to her hotel, had a daiquiri and two whiskey sours, and paid a bellhop to deliver a note to Eddie Waitkus's room," Phillips said.

The note read: "It is extremely important that I see you as soon as possible. We are not acquainted, but I have something of importance to speak to you about. I think it would be to your advantage to let me explain it to you."

Waitkus met Steinhagen, who shot him in the chest with a .22 caliber rifle, reportedly telling him that if she couldn't have him, then no one could. Waitkus recovered

please see ***Stalkers*** *on page 46*

PROF RISK MGMT

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ROYAL OTTAWA

1/4BW

PSYPREP

1/4BW

Photodisc

As Insurance Coverage Wanes, Psychiatric ERs Get Busier

Emergency psychiatry is "high stakes" medicine, in which decisions to admit or release patients are made with a minimum of time and information.

BY MARK MORAN

In a side wing of the emergency department at St. Vincent's Charity Hospital in downtown Cleveland, a workaday quiet prevails on a morning in the middle of the week.

There is little to distinguish the place from a general emergency department (ED): a central desk with computers is surrounded by observation rooms with beds, and in a nearby room a physician is evaluating a newly admitted patient.

Yet this is not your ordinary ED, but a specialized psychiatric emergency department, and the people who arrive here have primary psychiatric disorders. Like all emergency patients at St. Vincent's Charity, they enter and are triaged through the main ED, but once admitted to the psychiatric ED, they are treated by a staff psychiatrist, one of whom is on duty during each work shift.

While the psychiatric ED occupies a separate space, it is not a stand-alone operation, and the staff psychiatrist works in consultation with staff in the general medical ED to determine the best treatment plan.

"The psychiatric ED should be a seamless part of the whole emergency department," Philipp Dines, M.D., chair of the department of psychiatry at the hospital, told *Psychiatric News*. "A stand-alone might work well for patients with localized psychiatric problems, but that's not the reality of the patients who come here. The reality is that patients arrive with medical illnesses and behavioral conditions that complicate each other. I want the psychiatric ED to be truly integrated with general emergency medical care."

ED Flags System Dysfunctions

In operation for nearly 30 years as part of the hospital's mission to serve the community's health care needs, the psychiatric ED at St. Vincent's is the only one in Cleveland and one of only two in Ohio.

A mobile crisis team that treats emergencies in the community has reduced somewhat the number of psychiatric cases arriving at the hospital, but today the psychiatric service still treats between 15 and 20 patients a day. Patients are liable to arrive from anywhere in the city and whenever they cannot find care elsewhere.

"We get a constant stream of patients from other places, and our numbers fluctuate whenever there are stresses in the local health care system," Dines said.

In this regard, the psychiatric ED at St. Vincent's mirrors a national phenomenon: what happens in the emergency department is often the first indicator of dysfunctions in a larger system.

One red flag that has emerged nationally is the rising number of psychiatry patients seeking emergency care. Earlier this year a survey of emergency physicians found that 61 percent of the 353 emergency physicians who responded saw an increase in the number of mentally ill people seeking emergency care at their institutions in the previous six to 12 months (see charts on facing page). The survey, conducted online by the American College of Emergency Physicians (ACEP) with APA, the National Alliance for the Mentally Ill, and the National Mental Health Association, was publicized in the March edition of the ACEP member newsletter, reaching approximately 12,000 active members.

Of the 353 respondents, 62.7 percent attributed the escalation to cutbacks in state health care budgets and the decreasing number of psychiatric beds. Moreover, 67 percent reported an increase in "boarding" of people with mental illness—the practice of keeping patients in the emergency department until inpatient beds, or other places of care, are found.

Emergency psychiatrist Michael H. Allen, M.D., an associate professor of psychiatry at the University of Colorado Health Sciences Center, emphasized that the organization of emergency psychiatry services is highly variable from one region of the country to the next, and often from one part of town to the next.

He said that the increase in mentally ill patients seeking emergency care is related to the loss of public or private insurance: as individuals lose coverage, they are liable to lose any regular source of care they might have had.

"But the larger problem is that health insurance comes with such poor mental health benefits that it would be more accurate to count many people as effectively uninsured," Allen said. "They can get medical but not mental health care, which then forces disproportionate numbers into the emergency system for mental health problems. All of these factors have resulted in an increase in traffic in the emergency department related to mental health care, and a general feeling [among medical emergency physicians] that they are not well organized to take care of these patients." And that is not all that accounts for the increase.

"There has been a tremendous proliferation of children and adolescents presenting nationally in the emergency department," said Glenn Currier, M.D., president of the American Association for Emergency Psychiatry (AAEP). "In part this has been fueled by [the 1999 school shooting at] Columbine, because teachers now have a policy of zero tolerance and often bypass parents in deciding to send kids to the ED, often when subacute emergency mental health services would have been sufficient if available."

Specialized psychiatric EDs, like the one at St. Vincent's in Cleveland, are one answer to the overflow of mentally ill patients in general medical emergency departments. The exact number of such specialized services is unknown: the American Hospital Association stopped counting several years ago, and many hospitals have hybrid services, including mobile crisis units or on-site consultation services, which blur the definition of a specialized psychiatric emergency department (see facing page).

Currier said that the most recent AHA data put the number of psychiatric emergency departments at approximately 1,500. They tend to exist in large urban settings at

Glenn Currier, M.D.: "There has been a tremendous proliferation of children and adolescents presenting nationally in the emergency department."

academic hospitals that have the resources to staff a separate service and the volume of patients to make it worthwhile. Many more hospitals—especially those in rural settings—often have a psychiatrist available only by phone.

"We know there was a trend toward the proliferation of psychiatric emergency services that followed deinstitutionalization and the emergence of managed care," Currier told *Psychiatric News*.

Yet hospitals do not make money on such services: evaluation of the typical emergency psychiatric patient requires more time and resources than does a medical patient, and psychiatric EDs do not feed patients into money-making intensive care units as do general medical EDs.

Nonetheless, Allen believes the expertise that a psychiatric emergency service can offer is more cost-effective in the long run. "Medical EDs aren't organized to do diagnostic assessments," he said. "They are organized to do triage—the sickest cases go to the hospital, and everyone else gets sent somewhere else.

"Under that model, you wind up with people being admitted to the hospital who don't need to be, while those who don't get admitted to the hospital are lost to follow-up," Allen said. "So triage costs you more in the long run. You are better off devoting some resources at the front door, doing a good assessment, and starting treatments for people."

Practicing High-Stakes Medicine

In an environment in which mentally ill people are increasingly seen at an acute stage of illness, the psychiatrist with a specialized interest in emergency medicine is

Emergency Psychiatry Resources Online

Michael H. Allen, M.D., is past president of the American Association for Emergency Psychiatry and chair of APA's Task Force on Psychiatric Emergency Services, which issued an August 2002 report posted online at <www.psych.org/downloads/EmergencyServicesFinal.pdf>. Allen has also been a consultant to the Institute of Medicine's Future of Emergency Care Committee and presented an overview of mental health and substance abuse issues in emergency care at a February meeting of the group in Washington, D.C. Allen's presentation is posted at <www.iom.edu/project.asp?id=16107>. ■

liable to become a critical gatekeeper.

Currier reports that the AAEP has 500 members nationally, most of whom are practicing clinicians in psychiatric or general medical EDs. Several teaching centers offer informal fellowships in emergency psychiatry, and the association hopes to develop a curriculum that will serve as the basis for a formally recognized fellowship program.

Though subspecialty status is a possibility in the future, the field is likely to remain for now a stepchild of emergency medicine and psychiatry.

But Currier and Allen said that treating mentally ill people in an emergency setting demands a unique set of skills and the ability to collaborate with general medical staff. It is "high stakes" medicine, in which stark decisions between admitting a person to the hospital and releasing him or her into the community must be made within a narrow window of time and often with a minimum of information.

Allen said emergency psychiatrists must be especially good at assessing risk and determining the level of dangerousness to self or others. "Day in and day out, the emergency psychiatrist deals with patients who may have intense suicidal ideation but about whom the psychiatrist may have no prior knowledge," he told *Psychiatric News*. "Your assessment has to be finely tuned to that window of time, and the stakes are pretty high. So the emergency psychiatrist gets good at listening carefully and using his or her intuition about people."

As Currier observed, it is a psychiatrist's name that is liable to be on the order that releases a patient into the community after ED assessment and treatment. So where a patient goes afterward is critical, and emergency psychiatry requires outreach to the community to which a patient will return.

At St. Vincent's Charity Hospital, the patient or visitor emerging from its doors looks out across Interstate 90 at Jacob's Field and the Terminal Tower on Cleveland's downtown skyline. Located in the heart of Cleveland, the hospital is bounded by the Central and Slavic Village neighborhoods and by Cleveland's Industrial Valley.

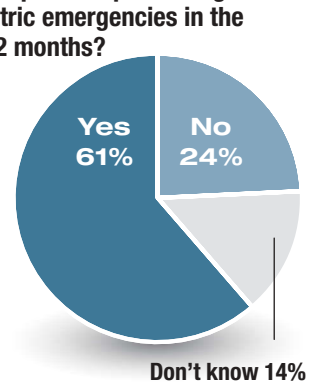
In addition to the inpatient psychiatric service, St. Vincent's Charity is home to Rosary Hall, which offers inpatient detoxification and outpatient addiction recovery programs, as well as inpatient and outpatient geropsychiatric/medical services.

But Dines said more psychiatry services are needed in the community. "People have an unrealistic view of the ED," he said. "They think, 'This person is mentally ill, and he's going to go to the emergency department and get better.' But the ED is only the beginning, only scratching the surface. The psychiatric ED is a useful model, but it is only as strong as our ability to connect to the community." ■

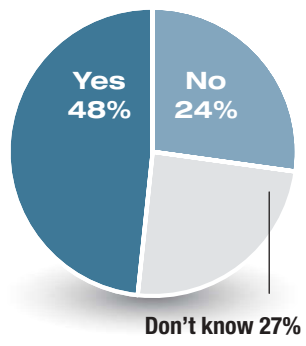
More Patients, Fewer Beds

A survey to which 353 emergency physicians responded asked for their perspective on recent shifts in psychiatric cases presenting in emergency departments.

Has your emergency department seen an increase in patients presenting with psychiatric emergencies in the past six to 12 months?



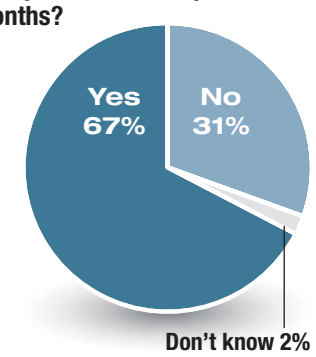
Has the number of psychiatric beds decreased in your region in the past six to 12 months?



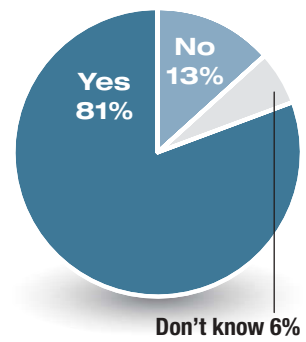
Source: American College of Emergency Physicians, Psychiatric Emergencies Survey, 2004

Boarding Counterproductive

Have you noticed more psychiatric patients "boarding" in your emergency department in the past six to 12 months?



Is the boarding of psychiatric patients having a negative effect on the care of other patients?



Source: American College of Emergency Physicians, Psychiatric Emergencies Survey, 2004

More Emergency Care Targets Kids in Crisis

An on-site consultative service makes sure psychiatric emergency care reaches youngsters in need.

There is more than one way hospitals can meet the need for specialized psychiatric services.

At Children's Memorial Hospital in Chicago, psychiatrist Richard Martini, M.D., directs an emergency department consultation service that provides on-site expert consultation to medical emergency department (ED) staff about patients with behavioral problems or mental illness.

As part of the department of child and adolescent psychiatry, the consultation service ensures the on-site presence of a child and adolescent psychiatry resident, psychology intern, and/or psychiatric nurse practitioner under Martini's supervision 24 hours a day. A social worker is also on site in the ED at night, Martini said.

> "These patients come to the ED because either the parents or the school feel they can't manage the children."

He confirmed the large and growing part that mental illness plays in emergency department visits by children and teens.

"Our ED sees kids of all ages," Martini told *Psychiatric News*. "We have had very young kids as well as preteens and adolescents who have threatened to hurt themselves, and a large number of children who are aggressive; threaten other kids, siblings, and parents; set fires; and are engaged in a variety of other dangerous behaviors. These patients come to the ED because either the parents or the school feel they can't manage the children."

Ensuring adequate follow-up in the community for those patients not admitted to the hospital is a constant challenge. "We have patients that may not meet the criteria for imminent danger to themselves or others, but whom we feel uncomfortable putting on a waiting list for outpatient care that may be weeks long," he said.

In those cases, an urgent care outpatient clinic linked to the hospital will see the child within seven days, providing a short-term therapy program that addresses the most acute aspects of the child's condition. The urgent care clinic can then transfer the child to outpatient treatment or, in the case of deterioration, to day or inpatient hospitalization.

Martini estimated that between 350 and 400 psychiatric emergencies come to Children's Memorial Hospital every year. A collaborative relationship between the consultation service and the medical ED staff has allowed for special accommodations—with regard to space and resources—for managing especially aggressive patients.

"Our ED is very busy, with approximately 45,000 visits a year," he said. "[Our psychiatric patients] are only 1 percent of the patients who come through the door, but we get attention because of how different our patients are and how much time they require." ■

Who Seeks Emergency Psychiatric Care?

Data from psychiatric emergency departments could supply critical information about a growing segment of people who need mental health care, but the resource is going untapped.

Schizophrenic, agitated, noncompliant with medication, possibly substance abusing—this is the picture of the typical person who comes to the psychiatric emergency department at St. Vincent's Charity Hospital in Cleveland, according to chief psychiatrist Philipp Dines, M.D.

The picture is not different from that seen in emergency departments elsewhere around the country.

A report in the February *Academic Emergency Medicine* confirmed a sharp increase in the number of mentally ill persons coming to the nation's emergency departments between 1992 and 2000.

Sara Hazlett, M.D., and colleagues at Johns Hopkins University School of Medicine reported that approximately 4.3 million psychiatric-related ED visits (PREDVs) occurred in the United States in 2000. The PREDV rates increased 15 percent between 1992 and 2000, and accounted for 5.4 percent of all ED visits in 2000.

A PREDV was defined as any visit in which one of three diagnoses included a psychiatric discharge diagnosis or suicide attempt coded according to the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)*, using codes 290-312.

Substance abuse (27 percent), neuroses (26 percent), and psychoses (21 percent) were the most common conditions. (Neuroses in the *ICD-9-CM* refers to anxiety, hysteria, and phobic disorders.) Other disorders included depression, personality and conduct disorders, and suicide or self-inflicted injury.

African Americans had significantly higher visit rates than whites, and persons on Medicaid had double the rate of PREDVs compared with the uninsured, and almost eight times the rate of those privately insured.

Patients with psychiatric diagnoses had a higher admission rate (22 percent) than those with nonpsychiatric diagnoses (15 percent).

The uninsured were the least likely to be admitted for all major psychiatric conditions except suicide.

Emergency psychiatrist Michael H. Allen, M.D., believes the ED is an untapped reservoir of information about a critical segment of mentally ill Americans and the care they receive. While the ED does serve as a kind of barometer for the dysfunctions of the larger system—the canary in the health system coal mine—the picture that emerges is impressionistic and lacking in detail.

"There are no multicenter data about who shows up in the ED, what their problems are, and what happens after they come to the ED," Allen said. "One of the things I would like to see is a multisite system of psychiatric surveillance to look at agitation, aggression, use of restraints, and suicide—these are major public health issues.

"Suicide is the thing we are most interested in, but over the years there have been lots of things that manifested in emergency settings that could have been studied at that level and addressed. But people have not put the resources into understanding those problems." ■

Complex Factors Keep Many Blacks From MH System

Stigma surrounding mental illness in African-American communities is preventing many from receiving quality mental health services.

BY EVE BENDER

Underrecognition of a range of mental health problems by clinicians, a lack of trust in the medical community, and poor access to mental health services are keeping many African Americans with mental illness from recovery.

William Lawson, M.D., Ph.D., who is chair of the psychiatry department at Howard University in Washington, D.C., illustrated these points at a seminar titled "African Americans: Facing Mental Illness, Experiencing Recovery," which was held in conjunction with the 2004 annual conference of the National Alliance for the Mentally Ill.

Lawson appeared with a number of experts on African-American mental health issues, including Michelle Clark, M.D., who is chair of APA's Committee of Black Psychiatrists and an associate clinical professor of psychiatry at the University of California, San Francisco School of Medicine.

> **"Individuals from disadvantaged life circumstances experience a high rate of stressors and may be at increased risk for PTSD."**

About 40 percent of African-American children are raised in poverty, and the median income of African Americans is just 60 percent of the median national income, Lawson pointed out. Mental health care is expensive enough that its cost is often seen as being prohibitive when people at the lower end of the income scale make spending choices, he said.

The fact that many African Americans don't receive needed mental health care is not just an issue of economics, however—a number of studies have shown that African Americans with the same level of health insurance as whites are less likely to receive care, he said.

Stigma is another barrier that afflicts would-be consumers in the African-African community, as well as those who can provide care in that community.

Lawson cited findings from a 1996 National Mental Health Association survey that found that 63 percent of African Americans believe that depression is a personal weakness, while only 31 percent believe it is a health problem.

Furthermore, only about 33 percent of African Americans surveyed said they would take medication for depression if their doctor prescribed it, compared with 69 percent of the general population.

Some African Americans view religion as a panacea for mental health problems. Almost two-thirds of African American respondents said they believe prayer and faith alone will successfully treat depression "almost all of the time" or "some of the time."

When African Americans do come into contact with mental health clinicians, they are more likely to be diagnosed with schizophrenia than are whites showing the same symptoms, according to findings from a number of studies.

This may be due to a number of clinician-related factors, such as the failure to elicit all symptoms in African-American patients, failure to understand ethnic differences in symptom expression, or racial stereotyping.

"Providers tend to de-emphasize feelings and emphasize psychotic or unusual experiences in black people," Lawson observed. In addition, "protective wariness" on the part of African-American patients may be misinterpreted by clinicians as paranoia.

For African Americans, the ramifications of being overdiagnosed with schizophrenia mean that compared with patients of other ethnic groups, they have more but shorter hospitalizations, fewer privileges as inpatients, less occupational therapy, and less psychotherapy, and they are more likely to receive antipsychotic medication, Lawson noted.

In addition, he added, "African Americans are more likely to get older antipsychotic medications, which are associated with tardive dyskinesia."

In contrast to patterns of diagnosing schizophrenia, African Americans are less likely than whites to be diagnosed with mood disorders such as depression, and "suicidal ideation often goes unrecognized," Lawson said.

According to Clark, posttraumatic stress disorder (PTSD) is also a significant problem in the African-American community, yet it is not adequately identified or treated by clinicians.

"Individuals from disadvantaged life circumstances experience a high rate of stressors and may be at increased risk for PTSD," Clark said.

Psychiatrists, primary care physicians, and other clinicians can improve their recognition of PTSD and other disorders in African Americans by taking steps to ensure that they are qualified to deliver culturally competent medical care, she noted.

Instead of waiting for African Americans to come to their offices, she encouraged clinicians and advocates to reach out to people in minority communities through screening and educational initiatives at barbershops, beauty salons, and other popular neighborhood spots. ■

Woman Recounts Long Journey From 'Loneliest Place in the World'

After experiencing an entire year as "the living dead," one woman describes, from the perspective of an African American, her descent into depression and talks about what keeps her well today.

BY EVE BENDER

Being a depressed woman is the "loneliest place in the world," according to mother and literary agent Karen Gormandy. Yet being a depressed African-American woman is "even lonelier."

Gormandy is a living testament to the fact that recovery from mental illness is possible, and she shared this message with attendees at a seminar held in conjunction with the 2004 annual conference of the National Alliance for the Mentally Ill (NAMI) held in Washington D.C., in September.

NAMI's Multicultural Action Center hosted the seminar, which was titled, "African Americans: Facing Mental Illness, Experiencing Recovery" (see facing page).

Gormandy became involved with NAMI as the mother of a son who was first diagnosed with schizophrenia and subsequently with bipolar disorder.

"My job as a family member was to be strong—to be his mother and carry the burden," she said. "You're not allowed to be depressed when you are a single mother, the sole provider. You are not allowed to be depressed when you are a minority."

Yet there was no ignoring the "long, slow fall" into depression that robbed her of her high school and college years.

Gormandy, a member of the "perfect family who came to America" from Trinidad, was expected by her parents to "fit into society, not get into trouble, and be brighter than everyone else in the class," she said.

Then her mother left. "I felt my mother left because I was unlovable," she said.

Gormandy soon became disinterested in school and began cutting classes. Eventually she skipped school altogether.

"Pretty soon I couldn't get out the front door," she said. Things went downhill from there.

"I spent the entire 10th grade in bed," she said. Gormandy hesitantly recalled the year that "was like living in a bubble."

When light entered her room, it was not comforting but "blinding," she said, and

> "The way I survive is by being part of the community, by being involved in NAMI, and by having an outstanding therapist. . . ."

voices were muffled.

"The whole world was happening to other people," she said. "I was not part of anything. It was like being the living dead."

Eventually Gormandy did get out of bed and finished high school, but faced her second episode of major depression as a college

please see ***Journey*** *on page 46*

NAMI Hopes America's Feet Will Do the Talking

APA, the American Psychiatric Foundation, and American Psychiatric Publishing Inc. contribute to a D.C. walkathon to raise awareness about mental illness and the need for more research.

BY CHRISTINE LEHMANN

APA has a long history of collaboration with the National Alliance for the Mentally Ill (NAMI) on initiatives designed to educate the public and raise awareness of issues related to mental illness.

Last month APA expressed its appreciation of and support for NAMI at a kick-off event for NAMI's first fundraising walk, to be held in Washington, D.C., on November 6. It is one of 50 NAMIWalks planned this year to raise support for NAMI programs and increase awareness of mental illness issues, said NAMI Development Director Joleen Bagwell at the luncheon.

Carolyn Robinowitz, M.D., treasurer of APA, thanked NAMI leaders and staff for their dedication and hard work. She presented NAMI Executive Director Mike Fitzpatrick with a check for $20,000 on behalf of APA, the American Psychiatric Foundation (APF), and American Psychiatric Publishing Inc. (APPI). APA was a presenting sponsor at $10,000, and APF and APPI were gold sponsors at $5,000 each.

Carolyn Robinowitz, M.D., presents a check to NAMI Executive Director Mike Fitzpatrick at the kick-off event for NAMIWalks in September in Washington, D.C.

"APA contributed to this walk not only to show support for NAMI, but also to encourage other mental health organizations and business partners to become involved," Robinowitz said.

She added that APA is proud that all the proceeds from the walkathon will be used to fund mental health programs. "The more research, education, and funds we can support to help fight for and improve the lives of those suffering most, the better we will be as a community and as a nation."

"Now we have the chance to prove that America's most political city can rally around such a universal health concern."

Robinowitz observed that APA and NAMI have collaborated for many years on the annual Mental Illness Awareness Week, which was held this year from October 3 to 9 (see page 20). "APA recognizes that developing and maintaining partnerships through outreach initiatives with diverse organizations is an effective way to share knowledge and advocate for the millions of Americans suffering from mental illnesses, including substance abuse disorders, every year."

Robinowitz continued, "Such partnerships lay the groundwork for sustainable, long-term collaboration with allied health organizations and friends in the business community with the shared goal of raising public awareness of important mental health issues."

That spirit of collaboration became the driving force for APA to become involved in the first NAMIWalks event, in Washington, D.C., Robinowitz mentioned. "Now we have the chance to prove that America's most political city can rally around such a universal health concern."

Robinowitz is a member of the Washington Psychiatric Society and will lead its team in the D.C. walk. APA staff also plan to participate.

Numerous other 5-K NAMIWalks already planned throughout the United States demonstrate a real support base for mental health in other major metropolitan areas.

Further information on NAMIWalks is posted online at <www.nami.org/template.cfm?section_namiwalks>. ■

PFIZER GEODON BIPOLAR
P4C

Photo: David Hathcox

Abdul Hadi Al-Khalili, M.D., a member of the Iraqi Society of Physicians and chair of the department of neurosurgery at the University of Baghdad, addresses the Medical Coalition for Iraq meeting at APA headquarters in September. "Security is our most urgent problem," he said.

Health Minister Faces Challenges

Iraq, *continued from page 1*

can Academy of Ophthalmology, moderated the September conference and coordinated the agenda with Ritchie and the organizing committee.

Brennan and Timothy Gibbons, M.D., of the American Academy of Orthopedic Surgeons and an Army reservist, spent two months last year developing the foundation for democratizing Iraqi medical societies based on mutual interest between Iraqi and U.S. representatives *(Psychiatric News*, April 2).

High-ranking U.S. government officials participated in the conference, including Senate Majority Leader Bill Frist (R-Tenn.), Surgeon General Richard Carmona, M.D., Joint Staff Surgeon Maj. Gen. Darrel Porr, M.D., and Department of State Under Secretary for Global Affairs Paula Dobriansky, Ph.D.

Abdul Hadi Al-Khalili, M.D., chair of the department of neurosurgery at the University of Baghdad, described grim public health conditions in Iraq and security conditions in Baghdad. Al-Khalili represented the Iraqi Society of Physicians.

Inadequate sanitation, purification of water, nutrition, and health care have taken their toll on the health of Iraqis. The rates of liver diseases, including hepatitis B and diphtheria, increased under Saddam Hussein, and the cancer rate tripled between 1984 and 2004, said Al-Khalili.

The mortality rate for infants and children more than doubled from 1990 to 1998. The United Nations (U.N.) had imposed sanctions on Iraq for its invasion of Kuwait in 1990, and the impact on Iraq's people and economy was devastating. Half a million children under age 5 were reported to have died between 1991 and 1998. To provide some humanitarian relief, in 1997 the U.N. established the Oil for Food program in Iraq. This allowed Hussein's government to sell some of its oil in exchange for U.N.-approved food and medical supplies. However, the benefits were limited because, experts claim, only a third of the oil revenue was used for the intended purpose. The sanctions were finally lifted after Hussein was ousted in May 2003.

Iraq's new minister of health, Ala'adin Alwan, M.D., faces enormous challenges. He has a budget of nearly $1 billion this year from Iraqi oil revenue; $578 million of it will go for pharmaceuticals and medical supplies, and the rest for operations and maintenance, said James Haveman, a former senior advisor to the interim Ministry of Health in Iraq. He also was the health advisor to former Ambassador Paul Bremer, the administrator of the Coalition Provisional Authority until the interim government was installed in May.

The United States contributed nearly $900 million for health care in 2004, "including $498 million for the construction of new primary care centers and the renovation of 18 maternal and pediatric hospitals to reduce the number of infant and maternal deaths," said Haveman. "About $17 million will be used for training health care staff, $300 million for new equipment, and $50 million for the new hospital in Basra," added Haveman.

He observed that when he arrived in Iraq in 2002, "the ministry's budget was $16 million for 26 million people under Saddam Hussein. This was a 90 percent reduction from a decade earlier."

A priority of the health minister is overcoming shortages of medical supplies and equipment allegedly stolen "under the corrupt U.N.-administered Oil for Food program, which was shut down," said Haveman.

Corruption was widespread under Hussein's regime, and "medical supplies and equipment often disappeared out the back door," said Haveman. To combat corruption, independent inspector generals have been installed in each of the ministries.

The Ministry of Health has been immunizing the country's 4.2 million children under age 5 against preventable diseases

Photo: David Hathcox

Coalition meeting organizers Col. Cameron Ritchie, M.C. (left), Maha Alattar, M.D., and Michael Brennan, M.D. (far right), pause for a photograph with guest speaker Abdul Hade Al-Khalili, M.D.

such as polio, diphtheria, and tuberculosis, according to the ministry's official Web site.

Al-Khalili complained that frequent power outages in Baghdad disrupt the hospitals' security and ability to refrigerate storage of vaccines.

Kidnapping Iraqi residents for ransom took place under Hussein, but the number of middle-class residents of Baghdad—including children—being kidnapped has risen sharply since Hussein was ousted, according to Al-Khalili.

"People are afraid to leave their homes and send their children to schools. A friend of mine hired three bodyguards, and he was still kidnapped," he said at the conference.

Al-Khalili was kidnapped in August at gunpoint. The four-day ordeal ended when his family paid the ransom to his kidnappers.

Health minister Alwan has asked the Ministry of Interior for help in protecting medical staff at hospitals. Guards have been posted at hospitals, including outside operating rooms, Al-Khalili told *Psychiatric News*.

The kidnappings have exacerbated the already dangerous situation in Baghdad. Bomb explosions by insurgents are killing more Iraqi civilians than American soldiers. When American soldiers return fire, civilians have been killed in the crossfire, said Al-Khalili.

"Security is our most urgent problem. When the insurgents are fighting in the districts where guards live and it's unsafe for them to leave their homes, we have to postpone patient operations scheduled that day," Al-Khalili said during the interview.

The health ministry allocated $3 million for mental health care this year, a fraction of the overall health care budget. "That was all we could afford, given so many primary health care needs," Haveman told *Psychiatric News*

About $500,000 of the 2004 mental health budget is for Iraqi-run programs for victims of torture, said Haveman.

Scores of Iraqis including children were imprisoned and subjected to sadistic torture by Hussein's government.

In response to concerns about security in Baghdad, Frist said at the APA conference that about 15,000 more coalition troops would be deployed soon to Iraq to provide more security for the nation's January elections. He did not specify the date of deployment. The total U.S. troop count in Iraq on October 20 was approximately 130,000 soldiers.

Al-Khalili said he would prefer the U.S. military to train Iraqi troops and police in how to handle kidnappings and hostage-taking incidents.

Frist is a volunteer on apolitical, short-term medical missions in Africa. He said that such voluntary efforts to assist developing countries are "the currency of peace."

John Howe III, M.D., is the president and CEO of Project Hope, an international health foundation with offices and programs in 24 countries including Iraq. Howe described the program in Iraq as a public/private partnership between U.S. Agency for International Development (USAID), the U.S. National Cancer Institute, the King Hussein Cancer Center in Jordan, and Project Hope. The goal is to help Iraqi children with cancer obtain state-of-the art treatment and to train health professionals in Iraq to provide appropriate care for them. Howe mentioned that a new children's hospital will be built in Basra with a $50 million grant from USAID.

Sen. Majority Leader Bill Frist, M.D. (R-Tenn., left) responds to a question, while John Howe III, M.D., president and CEO of Project Hope, looks on.

Baha Alak, Ph.D., an Iraqi-American board member of Life for Relief and Development, said the organization received a $12 million grant from USAID to build a small community hospital in Baghdad and a women's health center in Mosul, "which we ran for six months and left it with the local people," Alak said. Life for Relief and Development is now a global organization dedicated to alleviating human suffering.

Life for Relief and Development also partnered with the Coalition Provisional Authority, Iraqi Ministry of Health, Elsevier Foundation, AMA, and the Noor Foundation to distribute more than 30,000 medical textbooks and reference materials to hospitals, clinics, and universities in Iraq, according to a news release.

Security concerns surfaced again when conference participants discussed meeting in Baghdad for the second international medical specialty forum for Iraq next year. When the discussion turned to meeting in neighboring countries such as Jordan, Iraqi physicians were concerned about the impact on participation of Iraqi colleagues. Other Iraqi locations were suggested, including Kurdistan in the north, which is relatively calm.

Information on the Iraqi Ministry of Health and its accomplishments are posted online at <www.mohiraq.org/overview.htm>. Information on Project Hope in Iraq is posted online at <www.projhope.org/where/iraq.html>. Information about Life Relief and Development is posted online at <www.lifeusa.org>. ■

Iraq's Psychiatric Hospitals Confront Many Obstacles

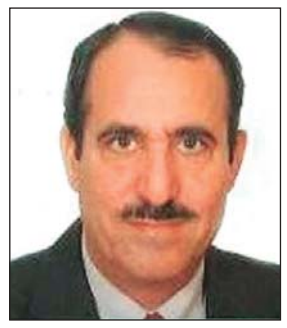
Baghad's psychiatric hospitals are refurbished and admitting patients following last year's looting. But frequent bomb attacks in civilian areas make it difficult for patients to keep appointments.

BY CHRISTINE LEHMANN

Imagine walking into a hospital where you saw patients just a week ago and finding it stripped of everything except for a few sticks of furniture. That was the condition Ibn Rushd Psychiatric Hospital was in last April after looters swept through the Baghdad hospital, said Iraqi psychiatric consultant Numan Ali, M.D., in a telephone interview with *Psychiatric News*.

"They took valuable medical equipment and supplies, medications, patient charts, computers, and furniture," said Ali, who is also the secretary-general of the Iraqi Society of Psychiatrists.

When Ali and his colleagues arrived at the hospital after it was looted, they found just a few boxes of medications that hadn't been stolen. The International Committee of the Red Cross made it possible for them to care for patients by donating hygiene kits with soap and towels, safe drinking water, first-aid supplies, stoves, and canned food.



Numan Ali, M.D.: "Doctors worry every day driving to and from the hospital about whether a bomb will explode and kill them."

Last May a Japanese non-governmental organization (NGO) visited the hospital and asked what Ali and his staff needed. "Within a short time, we had everything we asked for, and the hospital is completely refurbished," he said.

Japan also contributed $6 million to the reconstruction of mental health services in Iraq.

Ibn Rushd has 75 beds for short- and medium-stay patients, while Al Rashad has 1,000 beds for long-term patients, said Ali. Al Rashad was also looted and vandalized, and reportedly some women patients were raped. It has since been refurbished and is operating fully, although some 300 patients who left the premises last year haven't been accounted for, said Ali.

There are eight psychiatric consultants and eight psychiatric residents at Ibn Rushd, and at least 12 psychiatric consultants and 10 trainees at Al Rashad, Ali said. "The Ministry of Health is offering us new medicines and assistance, so conditions are better than last year."

He is pleased that psychiatrists and nurses are being paid triple what they were paid under Saddam Hussein, but added "we still deserve more."

The hospitals do not charge patients to stay there. There is a minimal fee of 500

please see ***Hospitals*** *on page 47*

Americans Help Iraqis Build Community Mental Health System

Experts from U.S. and Iraqi mental health agencies collaborate on planning community-based mental health care in Iraq and integrating it with primary care services.

BY CHRISTINE LEHMANN

Iraqis could have access to mental health care in their local primary care clinics in a few years if a U.S.-backed plan succeeds. Charles Curie, M.A., director of the Substance Abuse and Mental Health Services Administration (SAMHSA), visited Iraq in February and found that care is provided in psychiatric hospitals only—there are no community mental health clinics. Curie proposed U.S. help in developing community mental health care to his Iraqi counterpart Sabah Sadik, M.D. *(Psychiatric News*, April 2).

Charles Curie, M.A., is the director of the Substance Abuse and Mental Health Services Administration.

Sadik, an Iraqi psychiatrist who has lived for 25 years in the United Kingdom, is the interim mental health advisor to Iraq Minister of Health Alaa El-Din Alwan, M.D. Sadik told *Psychiatric News* that he agreed with Curie about focusing on creating a community-based mental health care system that can be integrated into the approximately 1,200 primary care clinics across the country.

Meanwhile, Curie has established a federal interagency planning group to work with Sabah and Jeffrey Brinkley, R.N., the new American health attaché to U.S. Ambassador John Negroponte in Baghdad.

The planning group is made up of representatives from the U.S. Army, the Department of Health and Human Services Office of Global Health Affairs, SAMHSA, and the National Institute of Mental Health, Curie told *Psychiatric News*.

Psychiatrist Col. E. Cameron Ritchie, M.C., is a consultant to the Army surgeon general and a member of the federal interagency planning group. "I am excited to be part of the planning team that is

please see ***Americans*** *on page 47*

association news

Children's MH Care Dominates Hill Briefing

A Capitol Hill luncheon during Mental Illness Awareness Week quickly became a venue for discussion of a topic of keen interest to legislators: pediatric use of antidepressant medications.

BY JIM ROSACK

APA joined with the National Alliance for the Mentally Ill (NAMI) on September 30 to host lawmakers and their health policy staffs at a Capitol Hill luncheon during Mental Illness Week. The topic was one of recent significance—"What's New in Children's Mental Health Research."

Held just two weeks after the Food and Drug Administration's public hearings on the use of antidepressant medications in children and the risk of suicidal thoughts and behaviors, the event gave both organizations the opportunity to focus lawmakers' attention on the facts concerning children with mental illness and specifically the significant lack of access to quality children's mental health care.

"Thank goodness we are finally paying attention to this very important issue," said Herbert Pardes, M.D., president and chief executive officer of New York Presbyterian Hospital and a former APA president, who served as host for the luncheon. "We are terribly underinvested in mental health in this country."

Several members of the House of Representatives attended at least part of the luncheon presentations, including Reps. Tim Murphy (R-Pa.), Joe Wilson (R-S.C.), Pete Stark (D-Calif.), Patrick Kennedy (D-R.I.), Sandy Levin (D-Mich.), Grace Napolitano (D-Calif.), and Barbara Jackson-Lee (D-Calif.).

Following a welcome by APA Medical Director James H. Scully Jr., M.D., Pardes introduced the keynote speaker for the luncheon, Peter Jensen, M.D., director of the Center for the Advancement of Children's Mental Health and the Ruane Professor of Child Psychiatry at Columbia University College of Physicians and Surgeons.

"We must find a way to close the gap between what we know and what we do," Jensen began, noting that two-thirds of all children in the United States with a diagnosable mental illness receive no care or treatment for their illness.

Jensen said the problem is, at the least, twofold: Americans in general are not sensitive to the warning signs of mental illness in children, creating a fundamental barrier to detection, identification, and diagnosis. While the reasons are many, he continued, one barrier is poor communication between patient/parent and doctor.

please see ***Hill Briefing*** *on page 48*

Rep. Barbara Jackson-Lee: The challenge is to make 2005 the year that Congress passes mental health parity.

Rep. Grace Napolitano: While there is progress on mental health issues, "there is a lot of work [left to do], and I implore you—don't stop."

Photos: Maureen Keating

Rep. Pete Stark says that the United States deserves "more open, transparent" research and drug advertisements in which benefits and adverse effects are printed in the same size type.

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Committee Begins Search For New *AJP* Editor

The successful candidate should have a strong background in the publication of peer-reviewed journals and experience with online submission and review systems.

APA and American Psychiatric Publishing Inc. are seeking candidates for the position of editor of the *American Journal of Psychiatry*.

The current editor, Nancy C. Andreasen, M.D., is completing the maximum term that an editor is permitted to serve on an APA publication—13 years. She was appointed initially in 1992, replacing John Nemiah, M.D.

Among the major responsibilities of the editor is to work in collaboration with the journal's Editorial Board, establish editorial policies, develop ideas for new features, and guide the journal in new directions. In addition, the editor directs the journal's Web-based peer-review process, assigning reviewers to submitted manuscripts and making disposition decisions.

Applicants must have significant publishing and editorial experience. Experience with publication of a peer-reviewed journal and with online submission and review systems is also desirable.

The editor reports jointly to the APA Board of Trustees and the medical director.

The position, which is part time, is salaried and does not require relocation. A transition period will begin in July 2005, and the new editor will assume responsibility for the January 2006 issue.

In March 1992 the Board of Trustees approved the following provisions with regard to the tenure and review of editors of APA publications: An editor is initially appointed for a three-year term. At the end of that time, a committee appointed by the president and medical director reviews the editor's performance. If the review is positive, the editor's contract is renewed for a five-year term. At the end of that term, a review is again conducted, and if positive, the editor can serve for five more years. Thus, an editor serves no longer than 13 years.

Applications must be received before December 31. They will be reviewed by a search committee, whose members are John M. Oldham, M.D. (chair), Jack D. Barchas, M.D., Floyd E. Bloom, M.D., Mina K. Dulcan, M.D., Glen O. Gabbard, M.D., Maria A. Oquendo, M.D., and Allan Tasman, M.D. Serving on the staff committee are James H. Scully Jr., M.D., Annelle Primm, M.D., M.P.H., Ron McMillen, and Sandra Patterson.

The committee hopes to begin interviewing candidates next spring and make a recommendation to the Board of Trustees in July 2005.

Psychiatrists may apply by sending a letter of interest and a curriculum vitae by e-mail to editor@psych.org or by mail to Editor, Search Committee, c/o Ronald McMillen, American Psychiatric Publishing Inc., 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209.

Further information about the editor position or a copy of the position description may be obtained by calling McMillen at (703) 907-7892. ■

Ohio Rep Gets APA*PAC* Contribution

Heather Queen-Williams, M.D., past president of the Northeast Ohio Psychiatric Association, presents Ohio Rep. **Sherrod Brown** (D) with a contribution from APA's political action committee, APA*PAC*. Rep. Brown is the ranking member of the House Energy and Commerce Committee's Subcommittee on Health. This subcommittee has jurisdiction over many of the legislative issues for which APA advocates. The presentation was made in Ohio and is part of an ongoing APA*PAC* program in which APA members educate federal legislators and policymakers about mental health issues.

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AMERICAN PROFESSIONAL AGENCY

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government news

APA Opposes Restrictions On Medicare Psych Meds

An unrestricted formulary in the new Medicare prescription benefit is the best way to manage cost concerns while maintaining access to critically needed medications for patients with mental illness, says APA.

BY JIM ROSACK

APA submitted extensive comments and recommendations last month to the Centers for Medicare and Medicaid Services (CMS) in response to CMS's proposed rule regarding the implementation of the new Medicare Part D Prescription Drug Benefit. The chief recommendation is a call for an alternative formulary for Medicare beneficiaries with mental illness diagnoses.

By "alternative formulary," APA is referring to a formulary that "contains no restrictions as to which drugs are available" for the treatment of people with mental illness.

Under the proposed rule, prescription drug plans (PDPs) that offer coverage under Medicare Part D would be required to create formularies for their Medicare beneficiaries and would be entitled to implement conventional cost-saving mechanisms such as preferred drug lists, mandated generic and/or therapeutic substitution, and step therapies including "fail-first" provisions.

For example, under proposed guidelines for formulary development, CMS would mandate a specific list of drug categories and classes that would have to be included by all PDPs. But current law requires that PDPs cover only "one or more" medications from each category or class. Thus, PDPs could include on their preferred drug list as few as three antipsychotic medications—one "phenothiazine," one "non-phenothiazine," and one "non-phenothiazine/atypical," the three proposed classes of antipsychotics required of all formularies.

Alternative Formulary Proposed

APA previously submitted extensive testimony and recommendations on the drug classes and categories proposed in the rule (*Psychiatric News*, October 1). In follow-up comments last month, APA recommended an "alternative formulary" that would exempt patients with mental illness from coverage under the standard formulary provisions and "provide immediate access to the relevant classes of drugs needed to treat this class of enrollees and their unique medical needs that correspond to their *DSM-IV-TR* diagnoses."

The comments and recommendations were prepared by APA's Division of Advocacy and Public Policy, through the combined efforts of APA staff in the departments of Government Relations and Healthcare Systems and Financing. The 24-page document painstakingly makes the scientific, medical, and legal case for CMS to allow an alternative formulary for beneficiaries with mental illness. (See related article in "Medical Director's Desk" on page 4.)

"Psychiatric medications are the essential technology component of contemporary medical treatment for these medical illnesses," the comments asserted. "The newer medications represent a significant advancement in treatment options that medical practitioners can utilize while minimizing the debilitating impact of severe mental illness and restoring patient functioning. Clinically appropriate access to state-of-the-art medications enables utilization of these clinical and technological advances to help millions of Americans treated in the mental health system."

Congress, in enacting the Medicare Prescription Drug Improvement and Modernization Act (MMA), said in the report of the House and Senate Conference Committee on the new legislation that CMS should pay special attention to the needs of Medicare beneficiaries with mental illness, ensuring that they have "clinically appropriate access" to appropriate medications. CMS specifically requested, within its Notice of Proposed Rule Making, that anyone representing vulnerable populations with unique medical needs comment on the best mechanism to provide clinically appropriate access to medications.

Specifically, APA recommended that an "alternative formulary be established for Medicare enrollees with a diagnosis as defined by the *DSM-IV-TR*, and cross-referenced by the appropriate *ICD-9* code, and for whom it has been determined that it is medically necessary that their condition be treated with a pharmacologic agent."

That formulary should include specific management mechanisms tailored to the unique medical needs of the population, and include payment-adjustment devices that "provide incentives for [prescription drug plan] participation and equitable compensation for the reasonable cost of the alternative formulary."

The need for an unrestricted formulary is verified, APA said in its comments, by the definition of Medicare beneficiaries with mental illness as a vulnerable population with unique medical needs and the use of medications that are not interchangeable therapeutically.

In addition, the comments stressed, the formulary-management strategies and the exceptions promulgated in the proposed rule are "unproven and will not facilitate treatment for vulnerable populations with unique medical needs." In fact, APA believes that "clinical outcomes will be gravely compromised and there will be negative fiscal consequences for the Medicare program if restricted formularies are permitted."

Alternative Strategies Proposed

APA's comments suggested that there are a number of alternative cost-management strategies that help to control rising prescription drug costs while not limiting access to care for vulnerable patients. These include medication algorithms, which guide physician choice of medications for specific illnesses toward those medications for which the strongest evidence base exists. In addition, disease-management programs, such as those developed for schizophrenia and depression, have been successful at slowing the steadily increasing costs of care. Prescriber profiling and education programs that aim to help physicians gear their

please see ***Restrictions*** *on page 42*

House Committee Briefed On Postpartum MH Issues

Research confirms that some women experience major depression and psychosis after childbirth, an APA leader explains to Congress.

BY CHRISTINE LEHMANN

After giving birth, many mothers experience fluctuating moods for a few weeks, while a minority experience severe depression that can last months.

Up to 80 percent of postpartum women experience the "baby blues" within 10 days of childbirth. This condition is characterized by rapid changes in mood and by irritability, anxiety, and tearfulness, explained Nada Stotland, M.D., a professor of psychiatry and professor of obstetrics and gynecology at Rush Medical College in Chicago.

Stotland, who is also APA secretary, testified on behalf of APA at a hearing held by the House Energy and Commerce Subcommittee on Health in late September on "Improving Women's Health: Understanding Depression After Pregnancy." Stotland discussed the impact of depression and other disorders in general on women and the importance of *DSM* as a diagnostic tool. She also urged Congress to pass the Sen. Paul Wellstone Mental Health Equitable Treatment Act of 2003 (S 486), which APA strongly supports.

Stotland, a constituent of health subcommittee member Rep. Bobby Rush (D-Ill.), testified at the request of subcommittee Democrats. Rush is the sponsor of the Melanie Blocker-Stokes Postpartum Depression Research and Care Act (HR 846), whose purpose is to provide for research on and services for individuals with postpartum depression and psychosis. The subcommittee members also heard from witnesses testifying about postabortion mental health issues.

An estimated 400,000 postpartum women in the United States are affected by some type of mood disturbance, said Stotland.

Postpartum depression affects between 10 percent and 20 percent of women. It develops within the first three months of birth and is more persistent and debilitating than the so-called "baby blues."

"It is often missed because new mothers are discharged quickly from the hospital, and the health care system is primarily focused on the care and well-being of the infant," Stotland testified.

Among the risk factors for postpartum depression are a history of depression, previous episode of postpartum depression, and depression during pregnancy, she explained. Episodes of psychotic illness can be triggered by the biological and psychological stresses of pregnancy and delivery. Researchers believe they are a manifestation of bipolar disorder, she continued.

"Psychotic episodes are rarer, affecting an estimated 1 to 2 women per 1,000 births. The signs include mood fluctuations, severe agitation, confusion, thought disorganization, hallucinations, and sleeplessness," she said.

"This is an extremely serious psychotic disorder that usually requires hospital treatment. Left undiagnosed or untreated, some mothers have committed infanticide followed by suicide," Stotland said.

Stotland also testified on allegations that postabortion depression and postabortion psychosis exist as diagnoses.

"Advocates of these designations typically argue without foundation that abortions can have a long-term impact on the mental health of women who elect to terminate a pregnancy," Stotland stated. Rigorous objective studies have confirmed that abortions are not a significant cause of mental illness, she emphasized.

That doesn't mean that some women who undergo abortions aren't deeply distressed, however. "But self-selected accounts of great unhappiness post abortion, however personally compelling, are not scientific studies," she said.

Stotland pointed out that unwanted pregnancy is a major stressor in a woman's life. In addition, the strongest predictor of postabortion psychological outcome is a history of depression prior to becoming pregnant.

"Other factors can include whether the pregnancy is terminated because of medical or genetic risks of complications and a feeling that the decision to abort wasn't freely made," Stotland testified.

"If Congress wants to take one single action that would make a world of difference for all women—for all persons—needing mental health care, I suggest that Congress promptly pass legislation to end discriminatory coverage of treatment of mental illnesses."

It can do so, she said, by passing the Sen. Paul Wellstone Mental Health Equitable Treatment Act. This bill, named in honor of the late senator who devoted much of his congressional career to mental health issues, is cosponsored by more than half of the House of Representatives and two-thirds of the Senate, she noted.

The bill would provide the same health insurance coverage for mental illnesses as provided for other medical illnesses, including the same financial and treatment limits.

The text of HR 846 and S 486 can be accessed online at <http://thomas.loc.gov> by searching on their respective bill numbers. Stotland's testimony is posted at <www.psych.org/advocacy_policy/leg_res/apa_testimony/20040929StotlandTestimonyonUnderstandingDepressionAfterPregnancy.pdf>. ■

Grants Target Intersection of Mental Illness, Justice Systems

APA supports a bipartisan effort to bring new federal resources to one of the most vulnerable and treatable populations in the United States.

BY KATE MULLIGAN

An APA-supported bill designed to help identify and treat people with mental illness in the criminal justice system has passed the U.S. Senate and the House of Representatives and will be sent to President Bush for signature.

In June APA submitted written testimony to the House Subcommittee on Crime, Terrorism, and Homeland Security for a hearing about the bill, the Mentally Ill Offender Treatment and Crime Reduction Act (HR 2387).

"People with mental illness make up one of the most vulnerable and treatable populations in our society, and yet they are housed in our most punitive institutions," APA wrote.

APA also pointed out that people with mental illness are significantly overrepresented in jails and prisons, are much more expensive to incarcerate than other inmates, are incarcerated longer than other inmates, and would be better served economically and medically by being treated in their communities *(Psychiatric News*, July 16).

The legislation authorizes the U.S. attorney general to award nonrenewable grants for collaborative and comprehensive proposals designed for adults or juveniles with mental illness or co-occurring mental illness and substance abuse disorders. The grants will be used by eligible applicants to create or expand the following:

- Mental health courts or other court-based programs for qualified offenders.
- Programs that offer specialized training to the officers and employees of a criminal or juvenile justice agency and mental health personnel in procedures for identifying the symptoms of mental illness.
- Programs that support cooperative efforts by criminal, juvenile justice, and mental health agencies to promote public safety by offering mental health and substance abuse treatment services.
- Programs that support intergovernmental cooperation between state and local governments regarding mentally ill offenders.

The attorney general must develop a list of best practices for appropriate diversion from incarceration of adult and juvenile offenders who need mental health care.

The Senate passed its version of the bill (S 1194) in October 2003 with a $100 million authorization. The amended version of S 1194, which passed October 12, authorizes $50 million.

The text of each bill can be accessed online at <http://thomas.loc.gov> by searching on its respective the bill number, HR 2387 or S 1194. ■

More States Unravel Health Safety Net

Progress in providing health care coverage to poor youngsters is threatened in many states.

BY KATE MULLIGAN

Signs of trouble with the State Children's Health Insurance Program (SCHIP), a mainstay of efforts to bring health care to low-income children, began to appear last July (*Psychiatric News*, September 3).

Reports issued then, which covered the fiscal quarter ending in December 2003, showed a decline in enrollment for the first time since the program began.

The program, enacted as part of the Balanced Budget Act of 1997, helped reduce the national percentage of poor children without insurance from 22.4 percent in 1997 to 15.4 percent in 2003.

A report commissioned by the Kaiser Commission on Medicaid and the Uninsured and released last month describes some of the strategies states are using to curtail enrollment and suggests likely trends in future coverage.

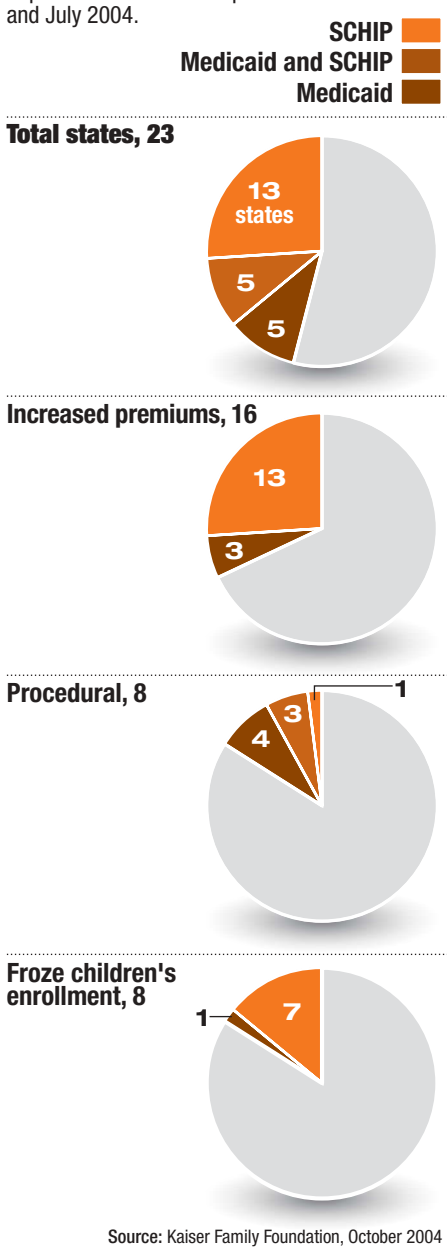
Donna Cohen Ross, lead author of "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families," and her colleagues at the Center on Budget and Policy Priorities, surveyed state officials concerning actions about SCHIP and Medicaid during the period from April 2003 to July 2004.

They found that 23 states had taken steps to restrict enrollment for eligible children and their parents through those two programs (see chart). Among them:

- Freezing enrollment for varying periods of time.
- Instituting methods that increased difficulties in enrollment. Those methods included requiring additional verification of income and age, reinstating face-to-face interviews, and restricting enrollment to certain periods of the year.
- Increasing premiums or expanding the population required to pay premiums. States began imposing premiums on families just above the federal poverty level, which is $15,670 for a family of three in 2004.

Access Gets Harder

The pie charts below illustrate barriers imposed on new enrollment to Medicaid and/or SCHIP and the number of states that imposed them between April 2003 and July 2004.



Source: Kaiser Family Foundation, October 2004

Ross pointed out in the report that the methods of increasing difficulty in enrollment often represented a reversal of policies instituted earlier to simplify and encourage enrollment.

She wrote that beginning in the 1990s, "states placed a high priority on enrolling uninsured, low-income children. . . in health coverage."

They increased access to coverage by expanding eligibility and designing streamlined enrollment systems featuring simple mail-in applications, minimal verification requirements, and guaranteed 12-month coverage.

Many states incorporated those changes into their Medicaid program, which helped change its image to a "health insurance program for working families."

But, because of budget constraints, the emerging trend is to retract procedures that have proved successful in increasing enrollment in the past.

In 2001 only one state had retracted a simplified procedure. By 2004, 11 states had reinstated one or more procedural barriers to coverage.

Ross concluded, "As states dispense with simplified procedures in Medicaid and SCHIP, the progress made on enrollment is in danger of unraveling."

"Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families" is posted online at <www.kff.org/medicaid/7191.cfm>. ■

VA Says 'Culture Change' Will Transform MH Services

The VA has responded to the New Freedom Commission on Mental Health with proposed action steps that promote "functional recovery" and expansion of mental health services.

BY KATE MULLIGAN

Federal agencies were asked to respond to the recommendations of the New Freedom Commission on Mental Health after submission of the commission's report to President George W. Bush in July 2003.

Among the first federal agencies to come up with an action agenda was the Department of Veterans Affairs (VA), which released "Achieving the Promise: Transforming Mental Health in the VA" on December 1, 2003.

Photo courtesy of the Department of Veterans Affairs

Frances M. Murphy, M.D., M.P.H., emphasizes the need for a culture change that focuses on "functional recovery."

Deputy Under Secretary for Health for Health Policy Coordination Frances M. Murphy, M.D. M.P.H., who served on the commission and chaired the work group that produced the VA report, told *Psychiatric News* that before the commission's work, "the VA had already begun a process for transformation" that is not yet complete.

She emphasized the importance of a "culture change" that focuses on the idea of functional recovery, rather than merely symptom reduction.

Work group members offered a candid assessment of key challenges.

Mental health workloads increased by 34 percent between 1995 and 2002.

Murphy said, "During Fiscal 2003, a total of 794,581 veterans, 16.9 percent of all VA patients, received specialized VA mental health [services]."

According to the report, "[Veterans] may have a higher prevalence of multiple diagnoses [and] mental health problems, such as PTSD and substance abuse, when compared with the general population."

The group wrote, "To date, the VA has not developed enough capacity in outpatient or community-based programs to adequately serve enrolled veterans' needs for screening, prevention, crisis treatment, and coordinated chronic health care."

The inadequacy of the capacity is exacerbated by the "variability" in quality and extent of mental health services, including those for substance abuse, depending on geographic location.

"[O]nly about one-third of the veterans who meet utilization criteria for Mental Health Intensive Case Management are currently enrolled in such programs. Consistent access to mental health care in Community-Based Outpatient Clinics (CBOCs) has not yet been achieved. Of 616 CBOCs in Fiscal 2001, 258 had no mental health visits, and an additional 78 report that mental health care accounts for under 5 percent of their workload."

Murphy pointed out that the VA also has substantial strengths.

"Parity is not an issue. There is no re-

please see ***VA*** *on page 42*

VA Announces Action Plan

"Achieving the Promise: Transforming Mental Health Care in the VA" lists nine principles that guide the Department of Veterans Affairs' response to the New Freedom Commission on Mental Health:

- Recognize mental health programs as uniquely important to veterans' overall health care.
- Develop a system of care committed to providing equal importance and access to quality medical and mental health care.
- Understand and value mental health as a public health issue requiring screening, prevention, and treatment programs as components of care.
- Commit to recovery-based, veteran- and family-centered mental health programs.
- Use best-practice and evidence-based interventions to promote the highest quality of care.
- Ensure that collaborative care models are incorporated into the VA's primary care team structure.
- Promote research programs based on recovery and finding means to prevent and cure mental illness.
- Require cultural competence and diversity in the VA's programs and staff. For VA staff, a critical additional requirement for cultural competence is knowledge about military culture, veterans' experiences in different combat eras, and their impact on veterans' health.
- Strive for continuous improvement in care for veterans with serious mental illness, including substance abuse disorders, and those who are homeless.

Drugs, CBT Combo Not Advantageous In Anxiety-Disorder Treatment

SSRI antidepressants and cognitive-behavioral therapy are equally effective in the treatment of people with generalized social phobia.

BY JIM ROSACK

For patients with social anxiety disorder, there appears to be no added benefit to combining two widely used treatments, new research shows. Unlike major depression, where combining cognitive-behavioral therapy (CBT) and pharmacotherapy has been shown to produce a synergistic boosting of patients' outcomes, patients with social anxiety disorder do just as well whether they receive an SSRI, a comprehensive form of CBT, or both.

Jonathon R.T. Davidson, M.D., an associate professor of psychiatry at Duke University Medical Center in Durham, N.C., along with colleagues at the University of Pennsylvania compared the efficacy of the SSRI fluoxetine alone, comprehensive CBT (CCBT) alone, placebo pill alone, the combination of CCBT plus fluoxetine, and CCBT plus placebo in 295 patients. The research, funded by a grant from the National Institute of Mental Health, was published in the October *Archives of General Psychiatry*.

Generalized social anxiety disorder, which the researchers referred to as generalized social phobia (GSP), has been estimated to affect as much as 14 percent of adults in the United States and begins early in life. It is often persistent and rarely remits.

Five Treatment Groups Studied

Patients were randomly assigned to one of the five treatment groups in the study, and independent raters were used who were blind to treatment assignment. Fluoxetine was started at 10 mg a day and increased to 40 mg a day by day 30 of the 14-week study. If subjects taking fluoxetine were not significantly improved on 40 mg a day and were tolerating the medication satisfactorily, the dose could be increased to a maximum of 60 mg a day. Compliance with fluoxetine/placebo was monitored through pill counts and medication logs.

The comprehensive form of CBT was a 14-week group treatment that combined "in vivo exposure" involving role playing, cognitive restructuring, and social-skills training. Skills training included how to begin a conversation with a stranger and how to improve certain social interactive skills, like maintaining eye contact. Sessions were held once a week and included both men and women therapists. The first two sessions were educational in nature, with later sessions advancing in difficulty with increased interaction between patients and therapists and between patients themselves.

All patients were independently rated at four, eight, and 14 weeks using the Clinical Global Impression–Improvement scale (CGI-I), the Clinical Global Impression–Severity scale (CGI-S), and the Brief Social Phobia Scale (BSPS) as the primary outcomes for the study. In addition, the Social Phobia and Anxiety Inventory was used as a secondary measure.

By week 14, 54.2 percent of those receiving both fluoxetine and CCBT reported "very much improvement" (CGI-I score of 1) or "much improvement" (CGI-I score of 2) in their social phobia. In the group taking only fluoxetine, 50.9 percent reported a CGI-I of 1 or 2. Of those patients assigned to receive only CCBT, 51.7 percent achieved a CGI-I of 1 or 2. Of those receiving the CCBT/placebo combination, 50.8 percent achieved a CGI-I of 1 or 2. Lastly, of those assigned to receive only placebo, 31.7 percent achieved a CGI-I of 1 or 2.

Faster Response Seen With Fluoxetine

"All active treatments were superior to placebo on primary outcomes," Davidson and his coauthors wrote. "Combined treatment did not yield further advantage. Notwithstanding the benefits of treatment, many patients remained symptomatic after 14 weeks."

However, fluoxetine was found to generate a faster response than the comparison treatments. By week 4, fluoxetine showed superiority to CCBT/fluoxetine together, CCBT/placebo together, and placebo alone. By week 14 the degree of improvement did not significantly differ between CCBT and fluoxetine.

"Such a finding suggests that greater advantage would accrue from a strategy of initial treatment with an SSRI, followed by augmentation with psychosocial treatment after four to eight weeks," the authors observed, noting they are planning to study such a treatment scheme for GSP.

Significantly higher rates of specific treatment-emergent events were noted on a few symptoms. Both insomnia and headache were more common in the placebo and CCBT/placebo groups compared with the CCBT group and in the CCBT/fluoxetine and fluoxetine groups compared with CCBT alone. This "indicates that pill taking itself (whether drug or placebo) is associated with a high rate of headaches and insomnia," the authors noted.

Similarly, nausea occurred more often in the placebo and CCBT/placebo groups relative to the CCBT alone group, and in the fluoxetine group, relative to the CCBT group.

Davidson and his coauthors wondered "whether longer-term pharmacologic treatment is necessary and if changes in the delivery of CCBT would improve results."

An abstract of "Fluoxetine, Comprehensive Cognitive Behavioral Therapy, and Placebo in Generalized Social Phobia" is posted online at <http://archpsyc.ama-assn.org/cgi/content/abstract/61/10/1005>. ■

ASTRAZENECA SEROQUEL
(CHEF)
P4C

Residual Depression Symptoms Respond to Short-Term CBT

A less intense course of cognitive-behavioral therapy than customary was possible because the symptoms that did not abate after pharmacotherapy were made the focus of psychotherapy.

BY MARK MORAN

A significant proportion of patients with recurrent depression might be able to withdraw from medication successfully and stay well for at least six years with a focused course of cognitive-behavioral therapy (CBT), according to a report in the October *American Journal of Psychiatry*.

The study compared short-term CBT (10 30-minute sessions once every other week) versus standard clinical management following successful treatment of a depressive episode with psychopharmacology.

"Cognitive-behavior treatment was found to be effective in decreasing the residual symptoms of depression," the authors wrote. "By deferring psychotherapeutic intervention until after pharmacotherapy, we were able to provide a less intense course of therapy than is customary. . .because psychotherapy could concentrate only on the symptoms that did not abate after pharmacotherapy."

The lead author was Giovanni A. Fava, M.D., of the department of psychology at the University of Bologna, Italy. His colleagues included researchers at the University of Bologna, the department of psychiatry at the State University of New York at Buffalo, and the department of statistical sciences at the University of Padova, Italy.

Extending Follow-Up to Six Years

Fava and colleagues designed their study as an extension of the 1990 study "Three-Year Outcome for Maintenance Therapies in Recurrent Depression," which appeared in the December 1990 *Archives of General Psychiatry*. That study found that a sequential approach to treatment of recurrent depression, using pharmacotherapy in the acute phase and CBT for residual symptoms, resulted in a significantly lower relapse rate at two-year follow-up.

In the current study, Fava and colleagues used a similar design to report six-year outcomes of CBT for prevention of relapse.

Forty patients who were diagnosed with recurrent major depression and had been successfully treated with antidepressant drugs were randomly assigned to either CBT or clinical management; in both groups, antidepressant drugs were tapered and discontinued. A six-year follow-up was undertaken, during which no antidepressant drugs were used except in the case of a relapse.

Criteria for inclusion in the study included, in addition to successful psychopharmacologic treatment of the most recent depressive episode, the following: a current diagnosis of major depressive disorder, a third or subsequent episode of depression with the immediately preceding episode occurring no more than 2.5 years before the onset of the most recent episode, a minimum 10-week remission between the most recent episode and the immediately preceding episode, and a minimum global severity score of 7 for the most recent episode of depression.

Exclusion criteria included history of manic, hypomanic, or cyclothymic features; active drug or alcohol abuse or personality disorder; antecedent dysthymia; and active medical illness.

Fava and colleagues noted that the CBT group also received "lifestyle modification" and "well-being therapy."

"Clinical experience has suggested. . . that recovered depressed patients are often unaware of the long-term consequences of a maladaptive lifestyle, which does not take chronic, minor life stress, interpersonal friction, excessive work, . . .and inadequate rest into proper account," the authors stated. "We postulated that both the presence of subsyndromal psychiatric symptoms and chronic stress exposure may cause. . .fluctuating and heightened neural or endocrine responses resulting from environmental challenge."

They added that treatment aimed specifically at restoration of positive functioning is also vital. "A specific well-being-enhancing psychotherapeutic strategy was the third main ingredient of the cognitive-behavior approach," they stated.

Findings After Six Years

At six years the group receiving CBT had a significantly lower relapse rate (40 percent) than the clinical-management group (90 percent). When multiple recurrences were considered, the CBT group had a significantly lower number of relapses than the other group.

"The cognitive-behavior intervention provided in this report was quite brief," the authors commented. "It is conceivable. . .that even better results might have been obtained with longer courses of cognitive-behavior treatment and if patients beginning to experience signs and symptoms of relapse had received additional booster sessions of therapy."

The study, "Six-Year Outcome of Cognitive Behavior Therapy for Prevention of Recurrent Depression," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/10/1872?>. ■

FOREST NAMENDA
P4C

FOREST NAMENDA
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FOREST NAMENDA
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FOREST NAMENDA
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Suicide Risk May Remain Decades After Sexual Abuse

Sexual abuse may amplify the desire for escape and cessation of psychic pain well into middle age and older adulthood.

BY MARK MORAN

Time may not heal all wounds when it comes to childhood sexual abuse. Older depressed women who experienced childhood sexual abuse prior to the age of 18 appear more likely to contemplate suicide or to have attempted suicide than same-age depressed women who do not have a history of sexual abuse, according to a report in the October *American Journal of Geriatric Psychiatry*.

"This study suggests that it is important for clinicians to think about and be aware of the value of asking older patients about a history of sexual abuse," lead author Nancy Talbot, Ph.D., told *Psychiatric News*.

Talbot said the study is the first to look at the effects on older women of childhood sexual abuse; attention has largely been focused on its effects on women in adolescence and early adulthood, she said.

"Many times with older hospitalized adults we may minimize the impact of early life experiences," Talbot said. "Adult life proceeds, and you accumulate more and more experience, and there is only so much the clinician can account for and think about with the patient."

Added to this is the likelihood that older women will not bring the subject up unless they are specifically asked, she said.

Talbot is an associate professor of psychiatry at the University of Rochester School of Medicine and Dentistry.

In the study, Talbot and colleagues evaluated 127 women over the age of 50 who were admitted to a psychiatric unit with a diagnosis of major depression. Of those, 18 women reported having experienced sexual abuse in their youth, defined as "unwanted sexual contact before age 18."

Of the 18, 15 (83 percent) had attempted suicide in their lifetime, and 12 (67 percent) had made multiple attempts. By comparison, 58 percent of women with major depression who had not experienced childhood sexual abuse reported at least one attempt in their lifetime, and 27 percent reported multiple attempts.

The abused women were also much more likely to have experienced suicidal ideation than those who had not been abused (67 percent versus 18 percent).

Suicide attempts and suicidal ideation were assessed according to the Scale of Suicidal Ideation, a 19-item, observer-rated measure of morbid and suicidal thinking administered in the week prior to interview or in the interval between a suicide attempt and the interview, whichever is shorter.

Data on sexual abuse history were derived from chart reviews of responses to the Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID) interview.

Those with a history of sexual abuse were also more likely to have at least one other Axis 1 diagnosis and a lifetime history of substance abuse.

"Perhaps sexual abuse amplifies the risk for a persistent desire for escape and cessation of psychic pain proceeding well into middle-age and older adulthood, marked by a history of chronic suicide ideation and multiple suicide attempts," Talbot and colleagues wrote in the *AJGP* article.

The study was supported by grants from the U.S. Public Health Service.

An abstract of the study, "Preliminary Report on Childhood Sexual Abuse, Suicidal Ideation, and Suicide Attempts Among Middle-Aged and Older Depressed Women," is posted online at <http://ajgp.psychiatryonline.org/cgi/content/abstract/12/5/536>. ■

Resource Spotlights MH in Elderly

A new Web site aims to be the "one-stop shop" for mental health information for older Americans.

The Geriatric Mental Health Foundation, established by the American Association for Geriatric Psychiatry (AAGP) two years ago, launched a new Web site in late September that provides information and resources on mental health care for older adults. The site, <www.GMHFonline.org>, aims to be a "one-stop site for information" on late-life depression, substance abuse, and dementia including Alzheimer's disease, as well as information for caregivers and more.

"Our goal is to educate the public about late-life mental health issues while providing information and easy-to-use online support for older adults and their families," said Stephen J. Bartels, M.D., M.S., chair of the Geriatric Mental Health Foundation. "Through education, we hope to reduce the stigma of mental illness and help older individuals stay healthy as well as seek appropriate treatment when it's needed."

Bartels, an associate professor of psychiatry at Dartmouth Medical School, is a past president of AAGP.

The site offers a "find-a-doctor" feature to locate specialists across the country. The feature searches from a database of clinicians who are members of AAGP.

AAGP established the Geriatric Mental Health Foundation to raise awareness of psychiatric and mental health disorders affecting the elderly, eliminate the stigma of mental illness and treatment, promote healthy aging strategies, and increase access to quality mental health care for the elderly. ■

Few Racial Disparities Evident In Frail, Depressed Elderly

Elderly homebound individuals with major depression may be a uniquely frail cohort that shares more in common across racial groups than the general population.

BY MARK MORAN

Major depression is undertreated among homebound elderly, but especially so among black homebound elderly, according to a report in the October *American Journal of Geriatric Psychiatry*.

But the same study found, surprisingly, that the prevalence of major depression did not differ significantly among black and white homebound elderly.

Previous studies of depression and racial disparities among seniors have provided conflicting evidence. Some studies have found higher rates of depression among older white adults, others have found lower rates in that group, while still others have reported no difference by racial group.

Study author Denise Fyffe, Ph.D., said the contradictory findings could stem from a failure to focus on black and white patients with similar medical conditions, given the strong association between illness and physical impairment and late-life depression.

She is a postdoctoral fellow at the Institute for the Elimination of Health Disparities at the University of Medicine and Dentistry of New Jersey's School of Public Health.

The data came from a study conducted by Martha Bruce, Ph.D., M.P.H., at Weill Medical College of Cornell University. The study was funded by the National Institute of Mental Health.

A random sample of 56 black and 458 white homecare patients aged 65 and over was drawn from a log of newly admitted patients to the Visiting Nurses Service in Westchester, a not-for-profit certified home health agency serving a 450-square-mile county north of New York City. A diagnosis of major depressive disorder (MDD) was determined by a trained research assistant using the Structured Clinical Interview for Axis I Diagnosis.

Similar prevalence rates of MDD were found across black patients (10.7 percent) and white patients (10.9 percent). Statistical analysis showed no significant racial differences in the prevalence of MDD after controlling for potential confounding variables, including education, poverty level, and cognitive functioning as assessed by the Mini-Mental State Exam.

Similarly, the percentage of patients reporting each of the *DSM-IV* depressive symptoms did not differ by race. Additional statistical analysis revealed no significant difference by race in any of the symptoms, after adjusting for the overall severity of depression as measured by the Hamilton-Depression Rating Scale.

Only one of the six depressed black patients (16.7 percent) received antidepressant medications, versus 32 percent of the white depressed patients.

Fyffe and colleagues acknowledged that the small size of the sample may account for the lack of a finding of racial disparity. But they say the finding may also represent a true "shared burden" of MDD among black and white elderly homecare patients.

"Although black and white patients may differ in psychosocial risk factors, cultural background, or attitudes that can influence either the risk of depression or its identification, the severe medical burden and functional frailty of this patient population may overwhelm the potential influence of these other factors in this setting," they commented.

In an interview with *Psychiatric News*, Fyffe suggested that the population of elderly homebound patients is an especially frail, medically ill cohort that may share more in common across racial groups than the general population.

Fyffe said the study underscores the undertreatment of depression in both racial groups, but especially among black elderly homecare patients. In future research, Fyffe said she hopes to examine factors that influence the undertreatment among minority homebound older adults.

An abstract of the study, "Late-Life Depression Among Black and White Elderly Homecare Patients," is posted online at <http://ajgp.psychiatryonline.org/cgi/content/abstract/12/5/531?>. ■

Report Available

APA members can now access the report "Teaching Mental Health and Mental Illness Prevention in the Schools" by APA's Corresponding Committee on Mental Health and Schools on APA's Web site.

The committee prepared the report in response to an issue the Assembly brought to its attention. Many psychiatrists are concerned about the lack of information about mental health and illness issues taught in the general health curricula of public schools. The committee's report includes Web sites and other information that can be used by those who want to offer information on mental health and illness for use in health classes.

The report is posted on APA's Web site at <www.psych.org/members/gov/assembly/maynovmtg/archives/May04/8.D.pdf>. ■

Brain-Receptor Abnormality Linked to Alcoholism Risk

Individuals who inherit abnormal receptors for glutamate may be at risk of alcoholism, perhaps because the altered receptors fail to warn them to stop drinking after they've consumed enough alcohol.

BY JOAN AREHART-TREICHEL

Although alcohol is the most widely used drug of abuse, it is only slowly giving up the secrets of how it causes addiction in the brain.

For instance, particular regions of the prefrontal cortex and thalamus have been found to "light up" when an alcoholic patient views pictures of alcoholic beverages (*Psychiatric News*, July 6, 2001). The brain's endogenous opioid system also appears to be involved in alcoholism. And now it appears that altered nerve receptors for the neurotransmitter glutamate contribute to the development of the disorder, a study reported in the October *American Journal of Psychiatry* suggests.

Specifically, a family history of alcoholism is a well-known risk factor for the development of alcohol dependence. Also, NMDA receptors for glutamate are known to be among the main targets of alcohol in the brain. So Ismene Petrakis, M.D., director of the Substance Abuse Treatment Program at VA Connecticut Healthcare System, and colleagues suspected that an inherited abnormality in NMDA receptors might be involved in alcohol dependence.

The researchers gave 29 healthy young adults with no family history of alcohol dependence and 16 healthy young adults with such a history 40-minute intravenous infusions of saline, low-dose ketamine, and high-dose ketamine on three separate days under double-blind conditions. Ketamine is an antagonist of NMDA receptors and produces effects similar to those of alcohol.

The researchers then compared responses of the two groups.

In both groups ketamine produced effects similar to alcohol such as euphoria and sedation. And both groups experienced similar "highs" and drowsiness from it. However, the group with a family history of alcohol dependence incurred significantly less dysphoria—that is, anxiety, depressive mood, somatic concern, and guilt feelings—in response to ketamine and significantly fewer negative symptoms such as emotional withdrawal and psychomotor retardation in response to ketamine than did the group without a history of alcohol dependence.

The researchers thus believe that persons with a family history of alcohol dependence inherit altered NMDA receptors, and such altered receptors then play a role in alcohol dependence, especially since other studies have shown that a reduced sensitivity to the dysphoric effects of alcohol is the strongest predictor of the

please see ***Alcoholism*** *on page 42*

Mood, Anxiety Disorders Often Independent of Substance Abuse

Primary care and mental health clinicians who see patients with mood or anxiety disorders should be prepared to assess them for substance use disorders, suggest the results of a study of co-occurring disorders.

BY EVE BENDER

About 20 percent of the 19.4 million American adults with a substance use disorder meet diagnostic criteria for at least one type of mood disorder, and about 18 percent of this group also meet criteria for an anxiety disorder.

A significant proportion of those diagnosed with a mood or anxiety disorder also turn out to have a substance use disorder, according to data from the 2001-02 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), which was conducted by the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

The data from the survey appeared in the August *Archives of General Psychiatry*.

Of the 19.3 million adults estimated to have a mood disorder, almost 20 percent had a substance use disorder as well, and of the 23 million adults estimated to have an anxiety disorder, almost 15 percent had a substance use disorder.

"These results highlight the need for all individuals in treatment to be fully assessed for the presence or absence of a range of psychiatric disorder," the authors stated.

Primary investigator Bridget Grant, Ph.D., used the NIAAA Alcohol Use Disorder and Associated Disabilities Interview Schedule–*DSM-IV* Version to detect drug and alcohol abuse and dependence, major depression, dysthymia, mania, hypomania, panic disorder with and without agoraphobia, social phobia, specific phobia, and generalized anxiety disorder.

Grant is chief of the Laboratory of Epidemiology and Biometry in NIAAA's Division of Intramural Clinical and Biological Research.

The sample used for the 2001-02 NESARC was based on the sampling frame of the U.S. Census 2000/2001 Supplemental Survey.

Approximately 1,800 lay interviewers with the U.S. Census Bureau administered the NIAAA Alcohol Use Disorder and Associated Disabilities Interview Schedule-*DSM-IV* Version to 43,093 adults aged 18 and older to assess the prevalence and comorbidity of a number of mental illnesses.

Respondents also answered questions about whether they received treatment during the preceding year for drug and/or alcohol abuse or dependence, as well as for a mood or anxiety disorder.

Grant assessed whether respondents met criteria for independent or substance-induced mood and anxiety disorders during the year prior to the interview.

Respondents were classified as having an independent mood or anxiety disorder if none or only some of the episodes were induced by drugs or alcohol. They were classified as having a substance-induced disorder if all episodes of mood and anxiety were induced by drugs or alcohol over the prior year.

These were among the findings:

- About 9.2 percent of the total sample—approximately 19.3 million adults—had an independent mood disorder, and 11.1 percent, or 23 million adults, had an anxiety disorder.
- Of the 19.3 million adults with a mood disorder, an estimated 202,211 people (about 1 percent) experienced episodes that were classified as being exclusively substance induced. Of the 23 million with an anxiety disorder, an estimated 50,980 (about .02 percent) experienced substance-induced anxiety episodes.
- Approximately 9.4 percent of the sample, or an estimated 19.4 million adults, were classified as having a substance use disorder. Almost 9 percent of Americans had an alcohol use disorder, and 2 percent had a drug use disorder.
- Almost 26 percent of respondents with a mood disorder and 12.1 percent of those with an anxiety disorder sought treatment during the 12 months prior to the survey.
- Of the estimated 1 million people with an alcohol use disorder who sought treatment, 40.7 percent had a mood disorder, 33 percent had an anxiety disorder, and 33 percent had a comorbid drug use disorder.
- Of the estimated 550,000 people with a drug use disorder who sought treatment, about 60 percent had a mood disorder and 43 percent an anxiety disorder.

"We found a high prevalence of alcohol and drug use disorders among people who went to seek treatment for a mood or anxiety disorder and vice versa," Grant told *Psychiatric News*.

She pointed out that a large majority of those disorders are independent. "In the clinical literature, the general consensus in the past was that for those who were alcohol or drug dependent, nearly 60 percent of all mood and anxiety disorders, particularly mood disorders, were substance induced," she said.

"However, we found a very small percentage of people who have substance-induced disorders—most of them are independent or what the *DSM* calls primary."

Grant pointed out that when clinicians falsely assumed that mood or anxiety disorders were substance induced, patients

please see ***Disorders*** *on page 42*

APA's Election Guidelines Emphasize Dignity, Courtesy, and Fairness

With the announcement of the Nominating Committee's selection of candidates for the 2005 election *(Psychiatric News*, October 1), the campaign season is under way, and members will want to be familiar with the campaign guidelines.

The APA Elections Committee is charged with establishing procedures, with the approval of the Board of Trustees, for equitable voting of the membership. These procedures are documented in the election guidelines section of the *Operations Manual.*

Guidelines prescribing members' election-related activities were established by the Board in the early 1970s, when APA began having contested elections. Restrictions on campaigning were initially adopted as an attempt to address at least four major concerns: (1) to guard against massive campaign efforts "buying" an election win, particularly if those efforts were financed by resources from outside the membership, (2) the revulsion against campaign committees and unwelcome bids for public support, (3) the growing distress of the membership at being deluged with campaign materials, and (4) a feeling held by an unknown proportion of the members that large-scale campaigning was inconsistent with their conception of APA's professional image. The concerns are as valid today as they were in the '70s, and the guidelines continue to address them.

There are three sections to the guidelines: for the candidates and supporters, for those holding appointed or elected positions in APA, Area Councils/state associations, or district branches; and for the use of electronic media.

The intent of the guidelines is "to encourage fair and open campaigning by APA members on a level playing field, foster opportunities for candidates to educate their colleagues about the issues and about their experiences and views; keep costs down, and maintain dignified and courteous conduct appropriate to the image of a profession." Personal attacks against opponents are not permitted.

Most important is the stipulation that candidates and their supporters must use their own resources for election activities (A.1 below). Use of APA, Area Council/state association, or district branch resources or personnel is prohibited. The limits on the number of letters that each person may write (400 letters or 100 for Area office) make it manageable for any member wishing to support a candidate (A.2 below).

The guidelines for use of electronic media should be noted carefully. While there are no limits on the number of campaign messages that may be sent by e-mail (A.3, first paragraph below), members supporting candidates in this way must include the words "APA Campaigning" in the subject line.

Further, the only APA-supported list serve that may be used for campaigning is Member-to-Member (A.3, second paragraph). District branch and Area list serves may not be used. List serves of other psychiatric organizations may be used for campaigning only if permitted by those organizations.

APA's Web site will once again contain information about candidates, with links to the homepages of candidates who have Web sites.

The Elections Committee recognizes that there always will be problems in implementing the guidelines and in creating guidelines that are inherently equitable. However, over time members have indicated their satisfaction with the current guidelines, believing that the guidelines have achieved the objectives for which they were designed.

The Elections Committee encourages members to get involved in the election process, to support the candidates of their choice, and to encourage others to do so by writing personal letters or e-mail or by personal contact. The committee is open to suggestions from members on how to improve or change the guidelines.

We encourage you to vote and to urge your colleagues to do the same. Ballots for the 2005 election will be mailed December 22. Voting members with e-mail addresses on file with APA will receive an e-mail with instructions for voting online. Election information will be included in the December 3 issue of *Psychiatric News.* ■

This article was prepared by APA's Elections Committee.

APA Election Guidelines

A. Guidelines for APA Candidates and Supporters

The intent of the guidelines is to encourage fair and open campaigning by APA members on a level playing field; foster opportunities for candidates to educate their colleagues about the issues and about their experiences and views; keep costs down; and maintain dignified and courteous conduct appropriate to the image of a profession. Candidates are encouraged to state their own positions on issues and their own plans for the Association directly and positively, but may not make personal attacks against their opponents.

Campaigning (written or e-mail solicitation of votes or support) is discouraged until after Nominating Committee nominations are reported to the Board of Trustees. Members are encouraged to withhold commitments of their final support or votes until after all candidates are known. Members circulating petitions may not use the petition process for campaign/electioneering purposes beyond asking for signatures on petitions.

1. Money/resources: Candidates/supporters must use their own resources for election activities. Fund-raising is not permitted, nor is sharing of materials, such as letters, postcards, stamps (with the exception of mailing address labels or disks of mailing address labels). Candidates/supporters may not organize campaign committees, and candidates may not enter into agreements to campaign together. Use of APA, Area Council/state association, or district branch resources or personnel is prohibited.

2. Letters: Election "letters" include letters, postcards, and faxes asking for a member's election support. Follow-up mailings of a c.v., fact sheet, bio are permitted and are not included in the letter limits. Handouts may be made available at meetings attended by the candidate.

- Each candidate/supporter generates his/her own "letters" with his/her own personal resources; no APA, Area Council/state association, or district branch resources may be used.
- Each candidate/supporter may write up to 400 letters for candidates for national office or 100 for candidates for Area trustee.
- Mailing address labels or disks of mailing address labels may be purchased from APA, Area Council/state associations, or district branches and may be shared but not before the Nominating Committee has announced the candidates.
- Third-party endorsements are not allowed.
- Duplicated material may accompany each letter as a single attachment, but not multiple copies of attachments intended for further distribution.
- Candidates are encouraged to send a copy of these guidelines to members they ask for support.

3. E-mail: E-mail used for campaign purposes must comply with the intent of the guidelines with regard to content and must contain the words "APA Campaigning" in the subject line. There are no limits on the number of campaign messages sent by e-mail. Obtaining e-mail addresses is the responsibility of the candidates and their supporters; such addresses may not be as readily available as mailing addresses and are not to be provided by APA, district branches, or Area Councils/state associations. See also Section C.

APA list serves created for conducting business of an APA component or list serves using APA technology (except Member-to-Member) may not be used for campaigning. This includes district branch and Area Council/state association list serves. List serves of other psychiatric organizations may be used for campaigning if permitted by those organizations. See also Section A.5 below.

4. Presentations: Candidates may attend no more than four mutual presentations with their opponent(s). If all candidates have been given equal opportunity to attend and one cannot attend, the other candidate(s) may present but must count the presentation as one of eight made in his/her professional capacity (see below). The annual presentation at the Assembly counts as one of four mutual presentations by candidates for president-elect. In addition, grand rounds, lectures, presentations at APA meetings, and other kinds of presentations made in one's professional capacity should be limited to no more than eight during the campaign period. "Presentations" are those made to an audience with a significant number of psychiatrists, academic/psychiatric gatherings such as grand rounds, hospital lectures, etc. Running for office should not inhibit or prohibit candidates from conducting their usual professional business; every effort should be made to define "usual professional business" in the narrowest sense.

5. APA members in other organizations: All APA members are expected to abide by the APA election guidelines in APA elections, including in their capacity as officers and members of other organizations. APA requests that other organizations adhere to the intent of the campaign guidelines and provide fair and equitable coverage of opposing candidates.

6. Compliance: Each candidate receives a copy of these guidelines and a statement to sign, certifying that he/she has read the guidelines; promises to abide by them; will immediately report any deviations of which he/she becomes aware to the Elections Committee; and will notify and try to correct any supporter upon learning of an actual or potential deviation. The Elections Committee investigates any potential violation of which it becomes aware and reports violations to the Board of Trustees. The procedures used by the Elections Committee to investigate and report campaign violations are in Chapter 2 of the *Operations Manual* and will be sent to candidates with these election guidelines.

B. Guidelines for Those Holding Appointed or Elected Positions in APA, Area Councils/State Associations, or District Branches

1. Money/resources: APA, Area Council/state association, or district branch funds, services, or staff cannot be used to endorse, support, or promote any candidate; however, Area/state association or district branch funds—not APA funds—may be used to support the expenses of candidates invited to the Area Council/state association or district branch meeting for election purposes (see #3 below). APA, Area Council/state association, or district branch organizational stationery cannot be used. Candidates/supporters who hold appointed or elected APA, Area Council, state association, or district branch positions may refer to their titles in the body of the letter, but if they choose to sign the letter, they may not do so over their APA organizational title. Likewise, e-mails should not be "signed" using an APA organizational title.

2. Newsletters: Area Council/state association or district branch newsletters may announce as news items of up to 150 words per candidate the candidacy for national office or Area trustee of member(s) of that Area Council/state association or district branch with pictures. Editorial endorsement of candidates is prohibited, as are letters to the editor in support of or opposition to candidates. Newsletters may print statements or other materials by or about a candidate only if they give equal opportunity to opposing candidates. Newsletters cannot be distributed beyond the usual newsletter distribution.

3. Meetings: Candidates invited to attend Area Council/state association or district branch meetings to campaign may do so only if their opponent is also invited to the same meeting. Candidates invited to make scientific presentations at Area Council/state association or district branch meetings may not discuss election issues unless their opponents have been given an equal opportunity to do so.

C. Guidelines for Use of Electronic Media

Candidates and their supporters using electronic media for campaign purposes are expected to comply with the guidelines set forth in Section A and Section C.

1. APA's Web site: APA will include information on all candidates (the photos, biographies, and statements printed in *Psychiatric News)* and on the election itself (campaign guidelines, ballot mailing and return dates, etc.) on its Web site. This election information can be accessed through the election logo and linked to other information as appropriate.

2. Candidates' homepages: APA will provide links from its Web site to the individual homepages of the candidates. Each candidate is responsible for setting up and financing his/her own homepage, as well as any campaign communication on Member-to-Member. There will be a disclaimer on APA's Web site stating that candidates' homepages are their own creation and responsibility, and that APA takes no responsibility for information posted on them. APA reserves the right to cut the link between its Web site and a candidate's homepage if a candidate violates the campaign guidelines. No other individual, institutional, or organizational homepages will be used for campaigning.

letters to the editor

Roving Ambassador Needed?

I had the privilege of meeting with several high-ranking administrators of APA to discuss issues with regard to psychologist-prescribing bills. I spelled out my perceptions of APA's involvement, or lack of involvement, and noted that my perceptions may not reflect APA activities relevant to this national problem.

The APA leaders listened carefully and then described actions they had undertaken over the past years on psychologist-prescribing legislation, including the provision of financial and staff support to the district branches affected by the bills.

Since then I have spoken with a number of colleagues, and they share the perception about APA that I originally had had. What is clearly needed is a means to reflect the APA response on a more frequent and consistent basis. There is also a need for what I would call a "roving APA ambassador" whereby a psychiatrist designated as APA's representative travels around the country and speaks with district branches and state associations, psychiatry residents, and possibly medical students in a town-meeting setting. The person could provide updates from APA and invite input from members to take back to the Association.

As president of the Washington Psychiatric Society, I have had the opportunity to talk more fully with psychiatry residents in this region. They feel that APA has no relevance for them, and they do not feel district branch involvement affords them any advantages. These feelings continue as they move forward in their careers, and a serious apathy develops.

I believe that vigorous exchanges between district branches and residents could help turn their perception around, but doing so requires real, sustained commitment from the top. One meeting a year is meaningless, but two to three meetings a year might have a positive impact.

I welcome any feedback on this idea.

F. RODNEY DRAKE, M.D.
President
Washington Psychiatric Society

APA Medical Director James H. Scully Jr., M.D., responds:

I'd like to thank Dr. Drake for his thoughtful and constructive comments. It's good to know that he had a very positive interaction with APA. As he notes, the Board of Trustees has provided very substantial financial support—in the seven figures—to our district branches and state associations to help them with their own efforts to respond to the scope-of-practice crisis. Likewise, our dedicated national staff has worked to provide resources to our members to assist them in these efforts.

In the next few weeks, APA will again mail out to all district branches the latest version of a comprehensive, four-part resource packet on psychologist prescribing. Our national staff stand ready to help at any time.

I'm also committed to providing our members with the skills they need to be their own most effective advocates in Washington and at home. This March, for example, we revived our Advocacy Day, bringing 40 APA local leaders to Washington for grass-roots advocacy skill building and lobbying. In September we provided an intensive skill-building seminar to more than 80 APA fellows—tomorrow's leaders. And next year, we plan to bring some 100 APA leaders back to Washington for training and lobbying. We've also hired Lydia Sermons-Ward, our capable new director of communications and public affairs. One of Lydia's priorities is the rebuilding of our APA member public affairs infrastructure.

Dr. Drake's suggestion of a national "roving scope of practice ambassador" is worth considering. APA's Department of Government Relations also has a staffer dedicated expressly to the purpose of traveling on invitation to district branch meetings to provide hands-on advocacy training. In the next few weeks, he will be in Ohio, Arkansas, and Minnesota.

Finally, I've also made it a priority to reconnect APA national staff to our Area Council meetings, something that was curtailed for budget reasons in recent years.

Again, Dr. Drake's helpful comments and thoughtful suggestions are most welcome. I agree we need to do more to improve awareness of APA's role among psychiatrists, especially residents. APA is not the staff at headquarters—APA is more than 36,000 psychiatrists working to improve the care of persons with mental illness. Staff are here to help!

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.

government news

VA

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striction on the number of visits [to a mental health practitioner]."

She added that VA Secretary Anthony Principi "is such a champion for mental health."

(In 2002, Principi was the recipient of the APA Speaker's Award. He was praised particularly for his support of services for veterans with PTSD and for homeless veterans with serious mental illness.)

The work group agreed on a nine-item agenda to guide action (see box on page 29).

Murphy noted that the work group had identified a target date of 2008 to eliminate variability in access to mental health, substance abuse, and homeless services and to long-term psychiatric care.

That change will require expansion of specialty mental health services to all CBOCs. Telepsychiatry might be used in rural areas where it is difficult to recruit specialists who can treat such illnesses as PTSD.

The emphasis of the commission's report on promoting recovery and on greater involvement of patients and family members in making treatment choices is reflected in the recommendations of the VA's work group in the 2003 report.

The work group singled out 12 recommendations "of such high importance that implementation should begin in January 2004."

Among them are to adopt the recovery model in VA mental health programs nationwide, to educate VA staff on recovery, to develop a strategic plan for mental health research that supports VA recovery-based mental health, to initiate a national Recovery and Rehabilitation Task Force, and to develop a manual on establishing a peer-support program.

Murphy said that supported employment programs are a particular priority in terms of promoting recovery and the ability of veterans to live productively in the community.

Several recommendations promote the integration of mental and primary health care services.

How can mental health practitioners be confident that integration of services will not result in further erosion of resources for mental health care?

Murphy said, "Everyone worries they might lose something, but the VA is trying to increase access to high-quality care. . . .There will always be a need for mental health and substance abuse specialists."

She said that the goal is to "detect mental health problems early" and "keep care integrated as long as possible."

Murphy added that the veterans' population is aging. Those veterans prefer to have a primary care team coordinate their treatment.

"By involving mental health practitioners in the work of primary care clinics, veterans get a clear message that mental health is essential to their overall health." ■

Restrictions

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prescribing practices toward following accepted consensus guidelines for treatment have been shown to slow escalating costs of pharmacotherapy treatment.

In contrast, APA wrote, strategies such as prior authorization, "fail first," step therapy, and therapeutic substitution, employed in many restrictive formularies to contain costs, are likely to decrease overall quality of care in patients with mental illness. Ultimately, said APA, these strategies result in higher costs to the system through increased emergency and inpatient service utilization.

APA's document urges CMS to adopt the suggested unrestricted formulary and, at a minimum, "implement a grandfathering procedure" to help ensure continuity of care when patients transition from existing privatized or Medicaid coverage to the new Medicare Part D drug benefit.

"In the end," the document concluded, "we believe that an alternative formulary for this class of enrollees benefits both a vulnerable population and the success of the Medicare Part D program."

A copy of APA's comments and recommendations is posted online at <www.psych.org/advocacy_policy/reg_comments/cms-4086.pdf>. ■

clinical & research news

Alcoholism

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subsequent development of alcoholism.

In short, people who have inherited altered NMDA receptors may lack the warning signs to stop drinking after they have consumed moderate amounts of alcohol.

"This study," Petrakis said in a *Psychiatric News* interview, "is important in understanding one potential neurobiological mechanism for the development of alcohol dependence, where 'at risk' individuals may not experience the negative consequences of alcohol consumption (the 'brakes'), which, in combination with certain circumstances, may lead to repeated bouts of excessive alcohol use. Education for individuals who are 'at risk' (which is unfortunately still only loosely defined as those with a strong family history—one day genetic testing may be relevant) or for concerned parents of children at risk may alert them that they will need other. . . cues to regulate their drinking before it becomes a serious problem."

These findings constitute "an important clue in the search for biological factors that increase the vulnerability for alcoholism," Charles O'Brien, M.D., Ph.D., a professor of psychiatry at the University of Pennsylvania, said in an editorial accompanying the study report.

The study was funded by the National Institute on Alcohol Abuse and Alcoholism and by the Department of Veterans Affairs VA-Yale Alcohol Research Center.

The study, "Altered NMDA Glutamate Receptor Antagonist Response in Individuals With a Family Vulnerability to Alcoholism," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/10/1776>. ■

Disorders

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would not receive treatment for their mood or anxiety disorder because it was believed that once the drinking or drug abuse stopped, the disorder would vanish.

The NESARC findings indicate that mood and anxiety disorders should be more thoroughly addressed by substance abuse treatment specialists, and substance use disorders better addressed by mental health and primary care clinicians, she said.

An abstract of the study, "Prevalence and Co-occurrence of Substance Use Disorders and Independent Mood and Anxiety Disorders" is posted online at <http://archpsyc.ama-assn.org/cgi/content/abstract/61/8/807>. ■

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Stalkers

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from the shooting and returned to baseball, but did not return to his old form.

Similar cases of intimacy seekers described by Phillips included Margaret Ray, who stalked late-night television comedian David Letterman, and Athena Rolando, who stalked movie star Brad Pitt.

The rejected stalker is typified by the individual whose fantasies include the delusion that he or she has been rejected or slighted by the target of an obsession. In 1989 Robert Bardo shot actress Rebecca Schaeffer, with whom he had become infatuated after the actress made the mistake of responding to a fan letter from Bardo with a handwritten, personal note.

Hiring a detective to track down her address through the local division of motor vehicles, Bardo visited the actress where she lived and engaged her in conversation on her doorstep. When she rebuffed him, Bardo shot her, saying later that her behavior was "callous" and that he "expected more of someone like her," Phillips said.

In all of these cases, Phillips emphasized the deeply rooted, nearly intransigent nature of stalkers' fantasies.

"When assessing this cohort, you have to truly put yourselves where they are," Phillips said. "When you confront them with your reality, they will say, 'That is only your reality, because you really don't know.' " ■

Cultural Sensitivity

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Riba also cited APA's Department of Minority and National Affairs and drew special attention to a new project in the department designed to raise the national profile of APA in efforts to reduce and eliminate health care disparities.

The department's director, Annelle Primm, M.D., will visit regions of the country that have the highest proportion of underserved minorities. "APA district branches, primary care physicians, legislators, social service providers, and others we hope will engage in discussions on mental health disparities," Riba said.

Riba also cited new and ongoing projects by the Department of Minority and National Affairs including minority medical student and resident fellowships and internships, development of a speaker's bureau of minority psychiatrists, support for a minority research conference, support for culturally competent medical school curricula, and dissemination of a new recruitment video, titled "Real Psychiatry: Doctors in Action," which was previewed at the IPS meeting. (The next issue of *Psychiatric News* will carry a feature about the new video.) ■

Journey

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student in Montana, after her husband left her. She was absent from classes and was given academic probation.

"Montana isn't the best place to get depressed," she said. "There are no people around, and no one realizes you are missing. The phone never rang."

This time, however, Gormandy had to get out of bed to take care of her young son.

Today, she said, "the way I survive is by being part of the community, by being involved in NAMI, and by having an outstanding therapist who pulls me back every time I walk to the edge."

Gormandy doesn't dwell on the past, she said, nor on the future. "I take life one day at a time and appreciate the small joys I've been given. I have an incredible source of love and support from friends and from NAMI," she declared. ■

Americans

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working toward improving mental health care for all Iraqis," Ritchie told *Psychiatric News*. She has visited Baghdad twice and represents APA in the Medical Coalition for Iraq (see page 1). She is also a member of the APA Committee on Psychiatric Dimensions of Disasters.

Sadik also wants to expand the number of psychiatric units at general hospitals in Iraq from an estimated five to 20 units. This fits with Alwan's strategy of "folding psychiatry into general health services rather than excluding and isolating patients in a separate place," according to a July 12 interview with Alwan by Integrated Regional Information Networks.

Alwan and Sadik have said they will keep the only two psychiatric hospitals in Iraq open, at least in the short run (see page 19).

The concept of integrating mental health care and primary care is not new to Iraq, said Numan Ali, M.D., secretary-general of the Iraqi Society of Psychiatrists, in an interview with *Psychiatric News*. He is a psychiatric consultant at Ibn Rushd Psychiatric Hospital in Baghdad.

Iraqi psychiatrists began training primary care professionals to diagnose and treat mental illnesses in 1989 under the guidance of the World Health Organization (WHO), but their efforts were slowed by the U.N.-imposed economic sanctions, said Ali.

"We support the continuation of this effort so more Iraqis can obtain basic mental health services," Ali said.

Sadik recently asked Curie for U.S. expertise to address drug abuse and dependence, which is a new problem for Iraq. Ali attributed the recent appearance of illegal drug trafficking in opium and marijuana to Iraq's opening its border with Iran.

"Under Saddam, the border was closed, and anyone caught in possession of illegal drugs faced capital punishment," Ali said.

Ibn Rushd Hospital in Baghdad has a small drug-dependence unit. "It's not sophisticated, but we do the best we can with limited resources. We provide detoxification and counseling and discharge the patient to his or her family for monitoring," Ali explained apologetically.

Curie and Sadik agreed that the first priority is training interdisciplinary teams of Iraqi psychiatrists, psychologists, social workers, and nurses in psychiatric best practices. Sabah sees psychiatrists in the role of "team leaders much like in the United States."

Curie would like to train Iraqi interdisciplinary teams at academic institutions in the United States. "Many Iraqi physicians aren't familiar with the latest medical technology and equipment and best practices because of sanctions and deprivation under Saddam Hussein."

Sadik said Iraqi officials would rather conduct the training in Iraq, but they understand American security concerns about visiting Baghdad in particular.

The U.S.-Iraqi planning group will hold its first conference in December or January in the Middle East. Baghdad was chosen to host the conference, but due to the ongoing violence other sites are being considered including Kurdistan in northern Iraq; Cairo, Egypt; and Amman, Jordan, Curie said.

Ali was frustrated that meetings to plan Iraqi mental health care may be held outside of Iraq. "All this talk about improving mental health in Iraq, yet no one wants to come to Baghdad and see for themselves what is happening here."

U.S. State Department updates on Iraq are posted online at <http://usinfo.state.gov/mena/middle_east_north_africa/iraq.html>. News about Iraq's Ministry of Health is posted at <www.mohiraq.org/news.htm>. ■

Hospitals

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dinars ($.35 U.S.) for a psychiatric evaluation and medication, said Ali.

He is seeing more cases of acute stress and posttraumatic stress disorders among Iraqis. Ali believes the cumulative effect of three wars, sanctions, deprivation, and torture under Saddam Hussein has caused severe damage to the Iraqi psyche.

Although the hospital receives some medications from the Ministry of Health, it doesn't receive the newer atypical antipsychotic drugs, said Ali.

He complained that the supplies of psychiatric drugs that NGOs have sent have expired within a few months.

In May the Middle Eastern office of Janssen Cilag offered to send Ali a large supply of Risperdal through an international relief organization. As of mid-October, he had not received the tablets and was anxious about their status. The International Red Cross Committee withdrew its staff after its building was bombed, Ali said sadly.

Corruption is still a problem in Iraq, and medications sometimes end up being sold on the black market. "The proper channel is the Ministry of Health to avoid corruption," said Ali, who is anxious about his own safety. "Doctors worry every day driving to and from the hospital about whether a bomb will explode and kill them."

To make matters worse, doctors are being kidnapped and held for ransom by criminals. "At least 20 of my colleagues have been kidnapped at gunpoint and held for ransom, which their families paid. One doctor hired bodyguards who were shot by the kidnappers," Ali said. ■

Association News

Volunteers Needed

APA is seeking volunteers to be a part of its new APA Minority Fellowships Program Speakers Bureau. This list is intended to help put APA members in touch with minority experts in various fields willing to speak at allied health organization meetings, grand rounds, and other venues. Minority members of APA who would like to be added to the list are asked to contact Marilyn King at (703) 907-8653 or mking@psych.org.

Warning

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indicated beyond 12 weeks. Additional contact by telephone may be appropriate between face-to-face visits."

While the new warning language is specific to pediatric patients (those under 18), it also notes, "Adults with MDD or comorbid depression in the setting of other psychiatric illness being treated with antidepressants should be observed similarly for clinical worsening and suicidality, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases."

Drugs Required To Carry Warning

Anafranil (clomipramine HCl)
Aventyl (nortriptyline HCl)
Celexa (citalopram HBr)
Cymbalta (duloxetine HCl)
Desyrel (trazodone HCl)
Effexor (venlafaxine HCl)
Elavil (amitriptyline HCl)
Lexapro (escitalopram oxalate)
Limbitrol (chlordiazepoxide/amitriptyline)
Ludiomil (maprotiline HCl)
Luvox (fluvoxamine maleate)
Marplan (isocarboxazid)
Nardil (phenelzine sulfate)
Norpramin (desipramine HCl)
Pamelor (nortriptyline HCl)
Parnate (tranylcypromine sulfate)
Paxil (paroxetine HCl)
Pexeva (paroxetine mesylate)
Prozac (fluoxetine HCl)
Remeron (mirtazapine)
Sarafem (fluoxetine HCl)
Serzone (nefazodone HCl)
Sinequan (doxepin HCl)
Surmontil (trimipramine)
Symbyax (olanzapine/fluoxetine)
Tofranil (imipramine HCl)
Tofranil-PM (impramine pamoate)
Triavil (perphenaine/amitriptyline)
Vivactil (protriptyline HCl)
Wellbutrin (bupropion HCl)
Zoloft (sertraline HCl)
Zyban (bupropion HCl)

Four-Pronged Plan Announced

The new labeling is part of a four-pronged plan that also includes FDA's issuance of a new Public Health Advisory on the issue, a requirement that all antidepressant prescriptions—including new prescriptions and refills—must be dispensed with a patient medication guide, and finally, a requirement that antidepressant medications be available only in "unit of use packaging, sealed and labeled for one course of treatment."

The labeling changes, announced by FDA Acting Commissioner Lester Crawford, D.V.M., at a press briefing on October 15, were effective immediately.

Sandra Kweder, M.D., acting director of FDA's Office of New Drugs in the Center for Drug Evaluation and Research, noted that clinicians should receive their "Dear Healthcare Practitioner" letters sometime early this month and see the new labeling in new stocks of the medications distributed to pharmacies around the first of the month.

The patient medication guide had not been finalized at the time of the press briefing; however, Kweder said it should be completed "within the next few weeks," and patients should see it in the first half of December. The required "unit of use" packaging, however, may not appear for several months.

Kweder noted that manufacturers will be allowed to distribute all of their existing stock. In addition, she said, it will take some time to "retool" the packaging process at individual drug-production facilities across the country.

Psychiatric Groups Disagree

While some believe that the FDA abandoned the scientific evidence base and perhaps bowed to political pressure, FDA Acting Commissioner Crawford assured the public during the October 15 press briefing that "these conclusions are based on the latest and best science and reflect what we have heard from our advisory committees in the last month." Yet the advisory committees' support of a black-box warning and language directly linking the medications to suicidal thoughts and behaviors was not unanimous, and considerable discussion occurred during the advisory committee meetings regarding the strengths and weaknesses of the data upon which the warnings should be based *(Psychiatric News*, October 15).

In a joint statement, APA President Michelle Riba M.D., M.S., and President-elect Steven Sharfstein M.D., said, "The American Psychiatric Association believes antidepressants save lives. . . . We restate our continued deep concern that a 'black-box' warning on antidepressants may have a chilling effect on appropriate prescribing for patients. This would put seriously ill patients at grave risk."

Riba and Sharfstein said that APA is "working to help mitigate such an impact by collaborating with nonpsychiatric physicians—including pediatricians and general practitioners—to help them better understand their patients' needs and properly diagnose, treat, and monitor patients."

In addition, they noted, "we hope the FDA will set in place a system to track the impact of the black-box warning on prescribing patterns." Such a system, they said, should track any change in actions by patients to harm themselves as a result of reduced access to medically necessary treatment with antidepressants.

The American Academy of Child and Adolescent Psychiatry (AACAP) announced prior to October 15 that it did not support issuance of black-box warnings, stating that the data did not justify such a strong warning. In a press release following the FDA's announcement, AACAP said that it "applauds the careful consideration the FDA has shown in issuing the new warning with accompanying directives for more physician and patient information about side effects and monitoring."

AACAP also noted that in partnership with APA it has begun the process of providing "updated practice guidelines" and "a practice advisory" on the issue.

Psychiatric News will provide more in-depth information on the reaction of APA and other groups and researchers to the black-box warning in a subsequent issue.

The FDA posted information regarding antidepressant use at <www.fda.gov/cder/drug/antidepressants/default.htm>. It includes links to the new warnings, information on the advisory committee meetings, and the medications' data on suicidal thoughts and behaviors. ■

Text of Black-Box Warning

Suicidality in Children and Adolescents

Antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of [Drug Name] or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. [Drug Name] is not approved for use in pediatric patients except for patients with [Any approved pediatric claims here]. (See Warnings and Precautions: Pediatric Use)

Pooled analyses of short-term (4 to 16 weeks) placebo-controlled trials of nine antidepressant drugs (SSRIs and others) in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events on drug was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.

association news

Hill Briefing

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Perceptions Differ

"Nearly 80 percent of doctors say that they ask about a child's mental health during an office visit," Jensen said, citing data from a 2002 survey he and colleagues at Columbia completed. "But only one-third of parents believe the doctors ask that often, and 44 percent of parents stated that their pediatrician never inquires about their child's mental health during routine physical exams."

The gap must be closed, Jensen said, if children who need help are ever going to be identified. To do so, Jensen detailed a federally funded project he and his colleagues have been working on to identify a set of "indicators of unmet need—signs that [would lead] any mental health clinician to say, 'Hey, this kid needs help.' " That project identified a list of indicators, such as "extreme depression with impairment" or "suicidal, with recent attempt or plan."

Jensen noted, however, that many parents would not be comfortable with that type of language, so he and his colleagues translated the indicators into a set of "action signs." Instead of "extreme depression," words many parents would not use to describe their child, Jensen modified the wording to "extreme sadness and/or emotional withdrawal that last several weeks." Instead of the term suicidal, parents would be more likely to identify with the description "trying seriously to harm or kill oneself, or making plans to do so."

Despite the fact that "even the most severely disturbed children are likely to not receive any services, anywhere in the last year," Jensen continued, the child and adolescent mental health field has made significant progress on building an evidence base of scientifically supported treatments.

"Today we have well-developed and validated tools for both diagnosis and for treatment," Jensen concluded. "But we are not using them. We know what to do, but we aren't able to do it because we are trapped in a system that won't allow it."

Americans, Jensen said, must come together to fundamentally change the way we think about mental health care through a combination of policy initiatives that would expand primary care physician-patient time and invest in quality treatment tools for providers. Accurate information about mental health must be disseminated to parents, teachers, legislators, and policymakers, he added.

Following Jensen, David Fassler, M.D., an associate clinical professor of psychiatry at the University of Vermont School of Medicine and APA trustee-at-large, reviewed the FDA's re-evaluation of adverse-event data from clinical trials of antidepressants and discussed the black-box warnings that were widely anticipated at that time (see page 1).

Signs of Progress Emerging

NAMI Executive Director Michael Fitzpatrick told those in attendance, "This is truly a time of good news and of significant risk." He called on legislators to support funding of mental health research through the National Institutes of Health addressing appropriate diagnosis and treatment of mental illness in children and adolescents. He urged Congress to support initiatives to increase the number of mental health professionals specifically trained in the treatment of pediatric patients.

"We can and must do better," Fitzpatrick said. "Children may represent only a fraction of our population, but they truly are 100 percent of our future."

Many of the legislators in attendance noted in brief remarks to the group that while they are beginning to see signs of change in Congress, they remain frustrated at the slow pace of that change.

"We must help people to understand that treatment of mental health issues is a vital part of fundamental health care," said Murphy, himself a clinical psychologist. "When we do this, we'll get lower health care costs by treating the patient instead of the disease."

Kennedy added that the work of groups such as APA and NAMI are fundamentally "vital in keeping mental health issues in front of members of Congress and their staffs." He continued, "We have all of these issues that we need to address, but if we don't have basic parity, we'll get nowhere on any of it."

However, Napolitano said that she is seeing some signs of progress on mental health issues. "There is a beginning, a glimmer of recognition within this House of the issue that you talk about," she said. "But you need to keep getting information to your representatives. You need to make them understand that this is in their own backyards. These patients are their neighbors, their coworkers, their constituents."

Jackson-Lee noted "how frustrating it is that mental health remains a stepchild of the health care system of America. This is 2004, and we are still talking about something so fundamental as mental health parity. We must use the 2005 legislative session to really not give any leeway at all to any leadership [of the House or Senate] that does not support moving us toward mental health parity. You all can be a leading driving force in that, and I encourage you to be steadfast in working with Congress on that goal." ■