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American
Psychiatric
Association

PSYCHIATRIC NEWS

"See" references appear as fallows:

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Photo: Rachel Audi

APA President Michelle Riba, M.D., M.S. (center), celebrates the signing of the Garrett Lee Smith Memorial Act at a Capitol Hill reception last month with Sen. Mike DeWine (R-Ohio, left) and Sen. Gordon Smith (R-Ore.). See story on page 14.

Association News

Canadian Psychiatrists Confront Cultural-Competency Challenges

How does one provide culturally competent psychiatry in one of the world's most immigrant-friendly countries? Canadian psychiatrists who have had experience in this domain proffer some answers.

BY JOAN AREHART-TREICHEL

And there they were, the Moroccan daughter and her mother, in a Toronto hospital emergency room. The daughter was suicidal. Could it be because she was possessed by a malevolent spirit—a "djinn"? The mother thought so. Then the daughter admitted that she had done something terribly wrong. "Have you disgraced our family?" the mother asked.

This scene was play-acted by two psychiatrists at the annual meeting of the Canadian Psychiatric Association (CPA) in Montreal in October to provoke a discussion of how psychiatrists should handle such situations.

The scene is also an example of the cross-cultural challenges facing Canadian psychiatrists for several reasons—Canada is composed of peoples from numerous backgrounds, immigrants are settling in more areas of the country, psychiatrists are seeing more patients who have been tortured in their home country, and Canada is one of the world's largest immigrant-receiving countries. Some 150 languages are spoken in Toronto alone.

"I call it hyperdiversity," Laurence Kirmayer, M.D., director of transcultural psychiatry at McGill University, declared at the CPA meeting, whose theme was culture and mental health. "It is extraordinary."

Also extraordinary is the plethora of challenges Canadian psychiatrists face if they want to understand patients from different backgrounds and to help them, several speakers noted.

Certainly language is a daunting problem. Lisa Andermann, M.D., a postdoctoral fellow at the University of Toronto, said she sometimes uses an interpreter, but even so, the interpreter and patient may get so involved talking to each other that they forget the psychiatrist is there. Interpreters cannot always give a psychiatrist the context of what is going on with a patient, Dennis Kussin, M.D., a psychiatrist at Toronto Western Hospital, pointed out.

Patients may not be able to read the labels

please see ***Canadian*** *on page 18*

Association News

Who Will Be APA's Next Leaders?

The December 3 issue of *Psychiatric News* will contain information on the candidates running in APA's 2005 election. Ballots will be mailed to all voting members on December 22, and instructions for online voting will be e-mailed to all members for whom APA has an e-mail address on file. All ballots must be received by **February 7.**

APA ELECTION 2005

Professional News

Medical Students See Psychiatry's Diversity in New Video

APA hopes that its new video, "Real Psychiatry: Doctors in Action," will attract more minority members to the field of psychiatry and thereby lead to a reduction in mental health care disparities for minority patients.

BY EVE BENDER

Four psychiatrists are the stars of a new video documentary from APA in which the camera follows each through an average day in practice in settings ranging from an Indian pueblo north of Santa Fe, N.M., to a ramshackle apartment building in Baltimore.

The 27-minute video, "Real Psychiatry: Doctors in Action," is an initiative of APA's Department of Minority and National Affairs. Its goal is to increase the number of minority psychiatrists and raise awareness about mental health issues in patients from different ethnic backgrounds.

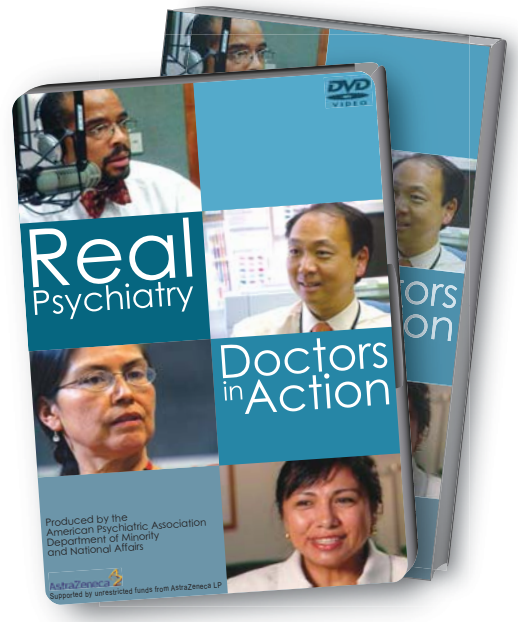
Through the video, viewers gain some insights into each of the psychiatrist's professional and personal lives.

" 'Real Psychiatry' is a valuable recruitment tool for psychiatry," said Annelle Primm, M.D., M.P.H., director of the Department of Minority and National Affairs.

Primm said she thinks medical students and others belonging to underrepresented groups will identify with the diversity of the psychiatrists in the video and "be enticed to consider careers in psychiatry."

Primm said the videotape "has tremendous potential to increase diversity in the psychiatric profession, which we know can help reduce mental health disparities among

please see ***Video*** *on page 34*



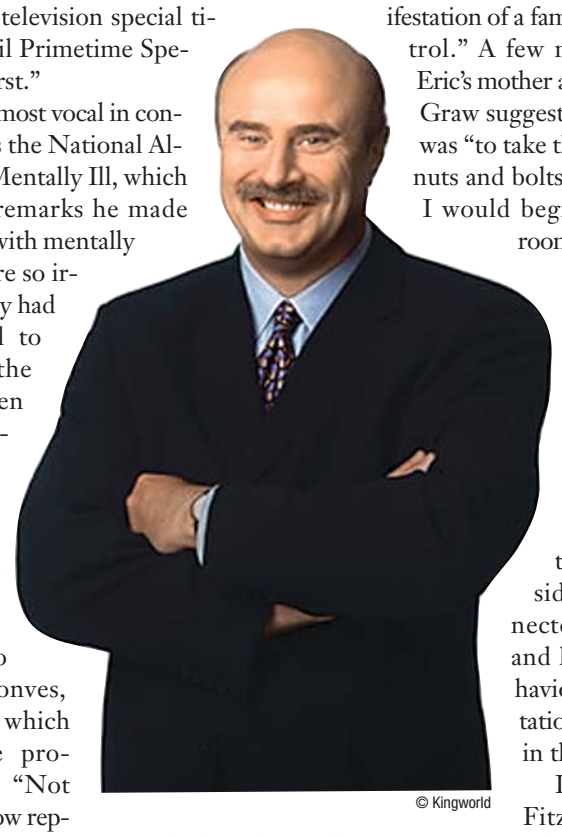
NAMI Leaders Issue Angry Response To TV Psychologist's Program

The aim of Dr. Phil's TV special may have been to show apparently dysfunctional families the path to improved functioning, but his comments have many mental health advocates saying that he is the misguided one.

BY KEN HAUSMAN

Television psychologist Phil McGraw, Ph.D., who says he has "galvanized millions of people to 'get real' about their own behavior," has recently managed to galvanize mental health advocates and others in anger and outrage over remarks that they view as anything but therapeutic.

The battle lines were drawn after his September 22 television special titled "A Dr. Phil Primetime Special: Family First."


© Kingworld

Among the most vocal in condemnation was the National Alliance for the Mentally Ill, which charged that remarks he made about parents with mentally ill children were so irresponsible they had the "potential to [endanger] the lives of children with mental illness."

NAMI Executive Director Michael Fitzpatrick wrote a blistering letter to Leslie Moonves, CEO of CBS, which broadcast the program, saying, "Not only did the show represent a breach of professional ethics, but also, in the opinion of many, malpractice."

Blaming family members—as McGraw appeared to do—for the behavior of a child who shows clear signs of mental illness, Fitzpatrick wrote, "undermines all recent understanding of the biological basis of brain disorders and is not only insensitive, but also hinders a family or individual from seeking comprehensive treatment. . . ."

The program's theme was showing, through videotapes of family interactions taken with hidden cameras, "out-of-control" families, including mothers and fathers making what he considers to be seriously misguided parenting decisions. McGraw is a Ph.D. clinical psychologist.

The segment that had NAMI members and others up in arms involved Eric, a 9-year-old boy who, McGraw said after seeing videotapes of his behavior, had nine of the 14 characteristics commonly evidenced by serial killers. "Jeffrey Dahmer had seven," he added. This occurred after his father dismissed Eric's behavior as the sort of things boys do, though the boy exhibited behaviors such as beating up his sister because he liked to watch her lip bleed, setting fires, abusing animals, and smearing his feces on the walls of his home. Eric interjected, "I don't like hurting them—I just can't help it."

McGraw concluded, "This is not a behavior problem with a child. This is a manifestation of a family that's out of control." A few minutes later, after Eric's mother asked for advice, McGraw suggested that the solution was "to take this child back to the nuts and bolts and re-parent him. I would begin by stripping his room totally. Take everything out of it except the bed. That's commando parenting. . . . You are in a power struggle, and the price of poker just went up."

McGraw urged the parents to consider how "interconnected" all families are and how their son's behavior "is just a manifestation of what's going on in the family."

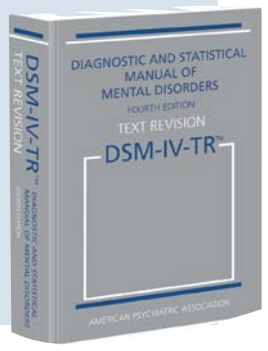
In his letter to CBS, Fitzpatrick stated that blaming parents for the behavior of a child with mental illness symptoms in front of an audience of millions puts "children's lives now at risk," since some parents will

please see ***NAMI*** *on page 34*

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.



Working Together to Prevent Youth Suicide

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

As psychiatrists, we experience, understand, and grieve a patient's death in various ways.

Especially challenging for us, professionally and personally, is when a young person takes his or her life. Nothing seems more contrary to our purpose as healers.

We are reminded that, even in the best of circumstances, not all suicides are preventable. But as the third-leading cause of death among young adults, suicide is all too common and a major national health concern.

It's some relief to know that we have tools in addition to our profession to help address the problem. Public policy and coalition work can complement and support our clinical work in meaningful ways.

Recently, the level of discourse between mental health advocates and public policymakers has increased. Together we are discussing how to prevent youth suicide and sharing in the anguish when youngsters are not reached in time. Sometimes the outcome of engaging in politics and policymaking buoys us; other times it presents us with an opportunity to redouble our efforts.

An encouraging development was the recent signing of the Garrett Lee Smith Memorial Act (see page 14), though the impetus for the federal government's new suicide prevention effort was a sad one: the September 2003 suicide of U.S. Sen. Gordon Smith's 21-year-old son.

"I didn't volunteer to be a champion of this issue, but it arose out of the personal experience of being a parent who lost a child to suicide and mental illness," Smith, a Republican, said this past summer on the Senate floor, urging passage of the bill.

Within hours, Smith's colleagues had approved the bill. Unanimously!

For me, just as heartening as unanimity in the Senate and timely passage of important legislation is the door that Smith opened for fellow senators to share their experiences with suicide and mental illnesses. Smith's heartrending remarks about his son were followed by moving testimonies from Sen. Harry Reid (D) of Nevada, whose father committed suicide after a years-long battle with depression, and Sen. Don Nickles (R) of Oklahoma, who shared a similar story about his father. Stigma faded a little that day.

The discussion ranged from medications and side effects to clinical trials and regulatory authority, and included personal stories about a loved one's suicide and calls to the FDA not to limit access to care.

Deep concerns over youth suicide have been front and center in another context.

In several forums APA has told the FDA that "as part of a comprehensive treatment plan, antidepressants can be extremely helpful and even lifesaving for many young people struggling with depression, an illness with significant long-term consequences, including an increased risk for suicide. We believe the biggest threat to a depressed child's well-being is to receive no care at all."

Indeed, throughout the process APA expressed its concerns to the FDA, Capitol Hill, the media, and the public about the potential for seeing treatment rates fall. APA leaders, members, and staff, in particular, were exceptional in their efforts to reach the FDA and encourage a patient-focused, science-based approach.

But personal stories seized the attention of everyone at the hearing—and some in Congress—and ultimately moved the FDA to adopt a black-box warning for all antidepressants *(Psychiatric News*, November 5).

Now recent prescription data, which pharmacy benefit manager Medco Health Solutions released a week after the hearing, suggest the controversy leading up to the warning has already lowered treatment rates *(Psychiatric News*, October 15). APA is committed to finding ways to stem that trend and mitigate potential adverse impacts of the black-box warning.

For more than six months, we have been working with family practice, pediatrics, and patient advocacy groups to draft guidelines for the treatment of depression in adolescents in primary care settings. This interdisciplinary coalition is known as Guidelines for Adolescent Depression in Primary Care, or GLAD-PC, and it's led by APA member Peter Jensen, M.D., of Columbia University. James MacIntyre, M.D., a child and adolescent psychiatrist in New York, represents APA on the initiative.

We are also in the process of establishing a work group among many of the same coalition partners, which will work quickly to provide information and advice for physicians and parents until the GLAD-PC guidelines are finalized.

And we have called on the FDA to set in place a system to track the impact of the new warning on prescribing patterns, a system that should also track any increase in actions by patients to harm themselves as a result of reduced access to medically necessary treatment with antidepressants.

We, as psychiatrists, are fortunate to be leaders in many efforts to intervene in support of our nation's young people and their well-being. Our clinical work, our advocacy, and our efforts across specialties are interrelated—each part vital to safeguarding the mental health of children and youth. ■

Have we heard from you yet? If you are one of the 1,000 APA members who received a readership survey in the mail from *Psychiatric News* and haven't responded yet, ***please do so today.*** Also, all APA members are invited to fill out the survey online. To access the survey, click on the above logo on APA's homepage. *Psychiatric News* needs to hear from as many members as possible to best respond to members' information needs.

PSYCHIATRIC NEWS READERSHIP SURVEY

Developmental Disabilities: Close the Training Gap

JEREMY VEENSTRA-VANDERWEELE, M.D.

Are we learning to help patients with developmental disabilities? I recently had the opportunity to participate in an APA workshop on advocacy on behalf of patients with developmental disabilities. In thinking about what I could offer such a discussion as a PGY-4 resident in general psychiatry, I considered my own experiences. I thought of one encounter when I wished that I could advocate effectively both for my patient and for better services in general. As I reflected, I realized that we should also be advocating for ourselves as residents to receive better training on how to help patients with developmental disabilities.

John (not his real name), a 30-year-old man with autism spectrum disorder and mild mental retardation, was brought to the emergency room by police after disrupting traffic outside a convenience store. John's parents were contacted, and they reported some increase in agitation and self-injurious behavior over the past week or two. I was paged to authorize John's fourth admission in the past six months. I wondered what I could do differently after two previous resident teams had failed, but I couldn't very well turn him away.

As I entered John's room, my spirits picked up. John was sitting on Power Rangers sheets and holding a well-worn Superman comic book. I started to like him as he talked excitedly about the bus outside his hospital room window being "right on time" that morning. We worked around to what had happened the day before, and he told me that the convenience store hadn't had his favorite candy bar, which was "not good."

Once I met with John and then John's parents, I got a sense of how I might help. First, his parents needed a clearer sense of his diagnosis and symptoms, since they had been told that he was "psychotic and maybe schizophrenic." I also noted that he needed a proper trial of an SSRI to help with his preoccupation with rituals and routines.

Moreover, John's parents were starting to have health problems, and they had been trying for more than a year to find a group-home placement for John. They had been offered an intermediate care facility, but were ambivalent because John would not be allowed to ride his bike.

A day later, I managed to reach John's caseworker. She too was frustrated at the lack of services for patients like John and detailed some frustrations with his family's unwillingness to take the intermediate-care placement. She promised to work with the family to find other options.

We discharged John after six days. I rotated off of the inpatient service but bumped into John's parents a month later during yet another admission. I was sad to hear that little had changed.

In talking with residents in other hospitals, my experiences with John and patients with developmental disabilities are quite typical. I'm luckier than most in that my residency program has a didactic series on mental retardation and other developmental disabilities, but we still have no explicit clinical experience with such patients, and we don't see them as outpatients.

Very little in the psychiatric literature discusses this gap in training. An article in the March *Psychiatric Services* described a survey study of a three-week experience of residents on a dual-diagnosis/mental retardation unit at Zucker Hillside Hospital in New York. According to the survey report, residents almost uniformly described this as an important experience, but even in this program, they received no outpatient experience with patients with developmental disabilities.

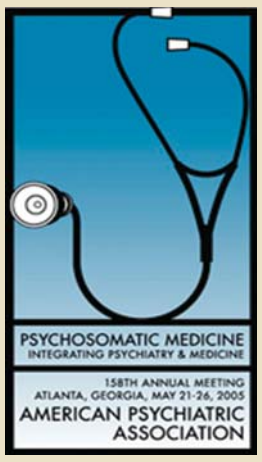
Is it really important to learn about developmental disabilities? The literature on developmental disabilities suggests that it is. Of the 1 percent of the population who have mental retardation, 30 percent to 70 percent have a psychiatric comorbidity. What should we be learning and how should we learn it? Early didactics and teaching on rounds and in clinical case conferences can show us the important role of the psychiatrist in caring for patients with developmental disabilities and their families.

The most important teaching may require a frame-shift in approach. We need to avoid learned helplessness with these patients, learning instead what we can and cannot do for them. Moreover, it is crucial to understand the psychiatrist's role outside of the clinic or hospital as a potent advocate. A well-placed phone call or letter from a physician can cut through layers of bureaucracy and resistance that families may not otherwise pierce. We need to gain comfort in the role of an expert who can redirect a system that so often goes wrong.

When I told one of my friends in the APA/GlaxoSmithKline fellowship that I was assigned to APA's Committee on Developmental Disabilities, she assumed that she needed to console me: "I'm sorry. That's too bad." That is sometimes the attitude that psychiatrists take in teaching and learning about patients with developmental disabilities. We care for them because they are there when we enter our inpatient units and clinics, but we rarely step outside the bounds of our collective learned helplessness. When considering advocacy for these patients, perhaps we first need to advocate for them within ourselves. ■

Jeremy Veenstra-VanderWeele, M.D., is a PGY-4 resident in child and adolescent psychiatry at the University of Chicago. He is also an APA/GlaxoSmithKline fellow serving on APA's Committee on Developmental Disabilities.

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.

MCOs Still Not Getting Mental Health Care Right

Managed care plans are doing a better job of providing quality treatment for many conditions—but not for mental illness.

BY MARK MORAN

Managed care plans that publicly report performance data showed significant gains in quality of care last year on several critical measures, but no gains were recorded on key measures in the treatment of mental illness, according to a report by the National Committee on Quality Assurance (NCQA).

The NCQA's annual report, "State of Health Care Quality," found that performance improvements recorded last year among the 563 managed care plans that reported their results were among the largest ever. These plans cover about 69 million people and represent a subsection of the broader health care system, according to the NCQA.

Average health plan performance in the area of controlling high blood pressure improved from 58 percent to 62 percent, an improvement that will mean about 2,500 fewer fatal heart attacks this year, according to the NCQA. Health plans are also doing a better job controlling the cholesterol of patients with diabetes; rates for that measure improved from about 55 percent to over 60 percent.

But the NCQA report specifically singled out mental health as an area where the performance of managed care plans has been dismal. Rates for two key measures—follow-up care and medical management of depression—remain generally low and indicate that patients get the correct care only about 50 percent of the time, according to NCQA.

The report is based on results from managed care plans that use the NCQA's Health Plan Employer Data and Information Set (HEDIS), a tool to measure performance on important dimensions of care and service. NCQA is a nonprofit accrediting organization for managed care organizations.

Lawrence Lurie, M.D., chair of APA's Committee on Managed Care, said the NCQA report is a worthwhile effort to measure quality across the health care system, but questioned what health plans are doing to remedy deficiencies in treatment of mental illness.

"What NCQA is measuring is important," Lurie told *Psychiatric News*. "Follow-up treatment after hospitalization is an especially critical issue. But the question I would raise is whether health plans are doing anything to provide incentives, or make it easier, for clinicians to meet the performance measures."

At least one psychiatrist and APA leader expressed deep skepticism about the integrity of the findings. Edward Gordon, M.D., chair of APA's Advisory Committee on Medicare and member of the APA Committee on RBRVS, Codes, and Reimbursement, called NCQA an apologist organization for the managed care industry. "If [the plans] cared about patient needs, they would take a position for parity in mental illness," he said.

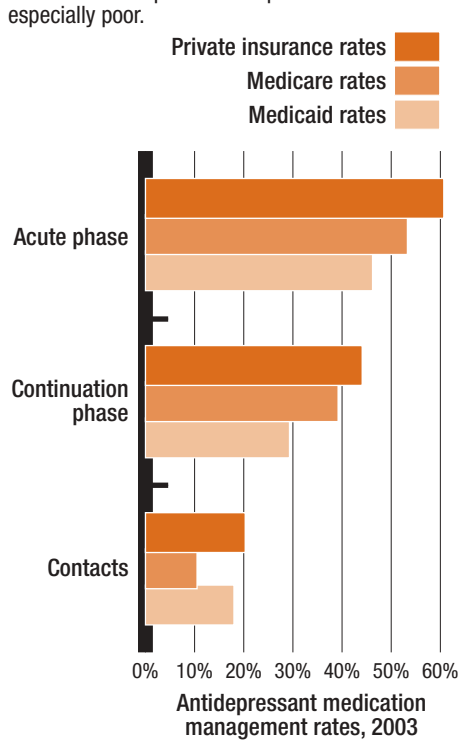
In the area of medical management of depression, the HEDIS measure looks at the percentage of members of a managed care plan with depression who received antidepressant medication during the acute phase (defined as the 12-week period following diagnosis) and the continuation phase (the six-month period following diagnosis). The measure also looks at the percentage of a plan's patients who received at least three visits with a clinician during the 12-week period following diagnosis.

In the commercial market, 60.7 percent of patients were prescribed antidepressant medication during the acute phase, and only 44.1 percent of all patients with depression remained on antidepressant medication

please see ***MCOs*** *on page 10*

Depression Care Inadequate

Rates of medication use for depression remain low in both public and private health plans, and rates of follow-up care for depression are especially poor.



■ **Acute phase:** The percentage of members who received antidepressant medication and had at least three follow-up visits in the 12-week acute phase after initial diagnosis.
■ **Continuation phase:** The percentage of eligible members who remained on antidepressant medication continuously in the six months after the initial diagnosis.
■ **Contacts:** The percentage of members who received at least three follow-up office visits in the 12-week acute treatment phase after a new diagnosis of depression.

Source: National Committee for Quality Assurance, 2004

Variety of Factors Keeping People From MH Care

Affordability of mental health treatment is the most formidable barrier keeping people from accessing care, according to a new government survey.

BY EVE BENDER

Serious mental illness affects an estimated 19.6 million American adults, or about 9.2 percent of the population, according to data from the 2003 National Survey on Drug Use and Health (NSDUH).

The number of people with serious mental illness has risen significantly from 2002 NSDUH estimates (17.5 million), according to a report of the survey's findings by the Substance Abuse and Mental Health Services Administration. The results were extrapolated to U.S. population estimates.

The NSDUH is a national representative survey conducted among almost 70,000 people in their homes. It collects information on the prevalence of substance use in the population, perceptions of risks related to substance use, patterns of use, treatment, and mental illness (see page 8).

The findings were released in September.

According to the NSDUH, an estimated 4.2 million adults met criteria for both serious mental illness and substance abuse or dependence during the previous year. Serious mental illness was defined as experiencing a diagnosable mental, behavioral, or emotional disorder that meets *DSM-IV* criteria and results in functional impairment that substantially interferes with or limits one or more major life activities.

For the purposes of the survey, substance abuse or dependence was distinguished as a separate category from serious mental illness.

The study found a strong link between serious mental illness and drug and alcohol problems.

Among adults with serious mental illness in 2003, 21.3 percent were also dependent on or abused drugs or alcohol. The rate among people without serious mental illness was just 7.9 percent.

About 21 percent of adults with substance abuse or dependence had a serious mental illness, according to the NSDUH. This rate dropped to 8 percent among adults without substance abuse or dependence.

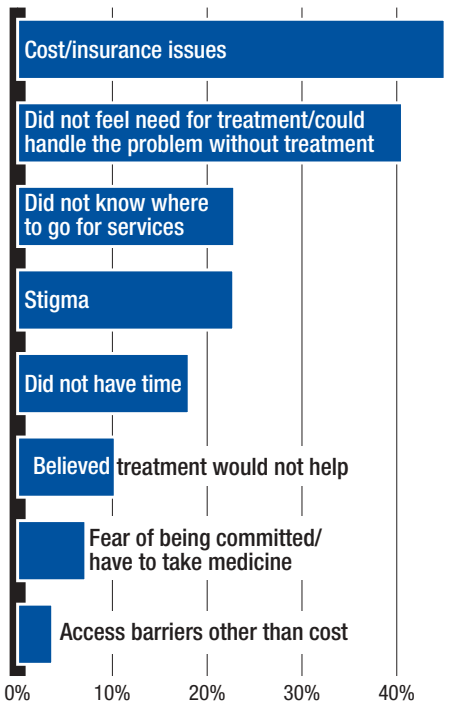
The survey also measured the prevalence of mental health treatment in the United States, defined as "the receipt of treatment or counseling for any problem with emotions, 'nerves,' or mental health" in an inpatient or outpatient setting in the year prior to the interview.

In 2003 an estimated 28 million adults, or about 13.2 percent of the population, re-

please see ***Cost Factors*** *on page 39*

Why Wasn't Treatment Sought?

Below are the major reasons cited in a SAMHSA survey by persons 18 years and older who met the criteria for serious mental illness but did not seek treatment.



Source: SAMHSA/National Survey on Drug Use and Health, 2003

Panahon Honored for Work on IMG Issues

Norma C. Panahon, M.D., is presented with APA's George Tarjan Award by **Prakash Desai, M.D.,** immediate past speaker of the APA Assembly. The presentation took place last month at APA's Institute on Psychiatric Services. The award, established in 1992 and named for George Tarjan, M.D., the first international medical graduate (IMG) elected president of APA, is given each year to recognize an individual who has made significant contributions to the enhancement of the integration of international medical graduates into American psychiatry.

Photo: Ellen Dallager

Panahon, an APA distinguished fellow, is medical director of outpatient services at the Buffalo Psychiatric Center in Buffalo, N.Y., and a private practitioner. She has a long history of advocacy on behalf of IMGs, having served as chair of the APA Committee on IMGs and the APA Caucus of Asian-American Psychiatrists and as president of the Philippine Psychiatrists in America. She continues to bring IMG concerns and perspectives to APA through participation in the Council on Social Issues and Public Psychiatry.

PFIZER GEODON BIPOLAR
P4C

Illicit Drug Use Patterns Show Small Changes

Prescription painkillers are gaining popularity among illicit drug users, while researchers find decreases in the use of certain once-popular hallucinogens.

BY EVE BENDER

While fewer people are using drugs such as marijuana, Ecstasy, and LSD, a greater number are abusing painkillers, according to data released in September by the Substance Abuse and Mental Health Services Administration (SAMHSA).

In 2003 an estimated 19.5 million Americans, or 8.2 percent of those aged 12 or older, were current drug users, defined as having used an illicit drug in the month prior to being interviewed, according to findings from the 2003 National Survey on Drug Use and Health (NSDUH).

Marijuana (including hashish) was the most commonly used illicit drug, with 14.6 million past-month users.

About half of current illicit drug users used only marijuana, while 20.6 percent used marijuana and another drug, and 24.8 percent used a drug other than marijuana in the past month (see chart).

Among current drug users, the most commonly used illicit drug after marijuana was cocaine (2.3 million users). About 1 million Americans used hallucinogens, 570,000 used inhalants, and 119,000 used heroin.

An estimated 6.3 million people aged 12 or older, or 2.7 percent of the population, used psychotherapeutic drugs nonmedically, including tranquilizers, stimulants, and sedatives.

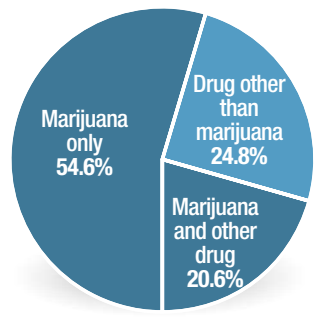
Each year SAMHSA sponsors the NSDUH, which is conducted by staff at RTI International in Research Triangle Park, N.C.

The survey, formerly known as the National Household Survey on Drug Abuse, collects information on the prevalence of substance use in the population, perceptions of risk and availability related to substance use, patterns of use, substance abuse treatment, and mental illness.

To obtain the latest findings, interviewers conducted home visits with 67,784 Americans from January through December 2003. The results were extrapolated to U.S. population estimates.

Marijuana Tops List

There were 19.5 million illicit drug users in the U.S. in 2003. Marijuana (including hashish) was the most commonly used illicit drug, with 14.6 million past-month users.



Source: SAMHSA/ National Survey on Drug Use and Health, 2003

Researchers Track Small Declines

Declines were noted in certain types of drug use between 2002 and 2003 among youth and adults.

For instance, the number of youth aged 12 to 17 who were projected to use marijuana on a daily basis dropped from 358,000 in 2002 to 282,000 in 2003.

The number of Americans aged 12 or older who reported using a hallucinogen in the year prior to the survey dropped from a projected 4.7 million in 2002 to 3.9 million in 2003.

Ecstasy use also dropped for "past year" users—the number of Americans aged 12 or older who reported using Ecstasy during the year prior to the survey decreased from a projected 3.2 million in 2002 to 2.1 million in 2003, a drop of about 34 percent.

LSD use was cut in half for past-year users, from 1 million in 2002 to 558,000 in 2003.

Use of Painkillers Rises

Researchers found that the number of Americans aged 12 or older who reported having ever taken a prescription pain medication for recreational use rose from 29.6 million in 2002 to 31.2 million in 2003.

Prescription pain medications for which there were statistically significant increases in lifetime use from 2002 to 2003 included the following (all numbers are projected estimates):

Vicodin, Lortab, or Lorcet (from 13.1 million to 15.7 million); Percocet, Percodan, or Tylox (from 9.7 million to 10.8 million); Hydrocodone (from 4.5 million to 5.7 million); OxyContin (from 1.9 million to 2.8 million); methadone (from 900,000 to 1.2 million); and Tramadol (from 52,000 to 186,000).

Drinking, Smoking Rates Steady

About half of those surveyed reported drinking alcohol, which translates to about 120 million people. "Current use" was defined as having at least one drink in the previous 30 days; data also identified binge and heavy use of alcohol.

Nearly 23 percent of Americans aged 12 or older, or 54 million people, partic-

please see ***Drug Use*** *on page 11*

Board Reviews Controversial Texas Restructuring Plan

The ramifications of a district branch's strategy for addressing its financial and membership problems take up a sizable portion of last month's Board of Trustees meeting.

BY KEN HAUSMAN

Current and former officers of APA's Texas district branch, the Texas Society of Psychiatric Physicians (TSPP), were invited by APA President Michelle Riba, M.D., to last month's Board of Trustees meeting in Phoenix to explain the details of and answer questions about the controversial establishment of two new psychiatric organizations in the state.

TSPP President Clay Sawyer, M.D., past president Priscilla Ray, M.D., and Robert Denney, M.D., a former TSPP representative to the APA Assembly, outlined how the new organizations—the Federation of Texas Psychiatry and Texas Academy of Psychiatry—came to be formed last summer.

They stated that the federation is an umbrella body whose members will be psychiatric and mental health organizations throughout the state. The academy is an organization for individual psychiatrists who don't belong to TSPP, which as a district branch requires dual membership in the branch and in the national APA.

Both TSPP, with its 1,345 members, and the new academy, which had 13 members as of mid-October, have joined the federation. The two members of the TSPP staff have resigned to become the staff of the federation, Sawyer said. The federation will provide administrative services for TSPP (see box on page 40).

TSPP, along with several other district branches, has been facing shrinking income and membership numbers that they say make it difficult to achieve its goals (though recent figures show the TSPP's membership decline may be reversing). As a way to bring more psychiatrists—and increased dues revenue—to TSPP, and to provide a voice for Texas psychiatrists who are not APA members, TSPP leaders had originally proposed an affiliates program in which psychiatrists could participate without also joining APA. Dues for the new affiliates were to be the same as for district branch members. Affiliate members would, however, avoid the dual-membership requirement.

APA leaders believed that this plan violated the Association's dual-membership policy.

Confronted with strong opposition and rejection of the plan by the Assembly Procedures Committee last November, as well as the possibility that the alleged violation of the dual-membership requirement could lead to TSPP's being "de-linked" from APA, TSPP's Executive Council decided in April to abandon the affiliates program.

The plan that eventually replaced it involved the formation of a separate organization open to non-APA members, which, TSPP leaders have maintained, had the approval of the then Assembly speaker, APA president, and Area 5 trustee. These APA leaders, however, disagree with this contention, saying that no specific endorsement of this or any other specific proposal was given.

Details Recounted

On March 15 then APA president Marcia Goin, M.D., wrote a letter to Ray, who was then TSPP president, informing the DB that at the APA Board's March meeting, Board members agreed with the Assembly's Committee on Procedures and its Executive Committee that the proposed affiliates program for nonmember psychiatrists would constitute a new membership category and would thus violate APA policy.

Goin stated that the Board was, however, "interested in supporting programs, activities, and other pilot projects to increase and strengthen membership in the TSPP and APA." She urged TSPP leaders to discuss additional ideas with the APA leadership, including ways in which APA "could provide assistance including support for communicating to members/nonmembers about any new [TSPP membership] project."

In April Goin attended a TSPP Executive Council meeting in Austin and learned that the TSPP had decided to establish a separate corporation for its affiliates program. She followed up with a letter to Sawyer informing him that the APA Board's Executive Committee was concerned about the implications of the plan and asking him to explain several facets of the new structure, including ones related to tax status, relationship with TSPP, membership parameters, sharing of staff, and financial factors.

In September APA learned from other sources of the two new corporations—the Federation of Texas Psychiatry and Texas Academy of Psychiatry—and TSPP's relationship to the federation ???????????? operations{Can't read JoAnn's writing}.

On September 30, Riba and Assembly Speaker James Nininger, M.D., sent a letter to all TSPP members in which they communicated the Association's position on the new organizational structure and related issues. Emphasizing that they are "deeply concerned" about what the actions of the TSPP mean for the future of organized psychiatry in the state, they explained their belief that "in establishing the academy and federation, TSPP leadership has set up organizations that will compete with TSPP and are certain to undermine its future. We are also concerned" that in backing the new structure, TSPP leaders are ignoring the DB's "obligation as an APA district branch and are undercutting APA" at a critical time "when advocacy is crucial and a central element of [APA's] mission."

Riba and Nininger, expressing their regret that a situation they tried to avoid came to pass, noted that APA has for years tried to help TSPP address its "problems of membership loss and financial needs. . . . While TSPP's membership recruitment and retention problems have been more severe than those of most other district branches, we have stopped and reversed the course of membership loss at APA and have helped other district branches do so as well."

Despite these and other communications between TSPP leaders and APA, Sawyer and other leaders maintained and told their members that APA had not given them sufficient opportunity to explain the function of the two new organizations and was spreading misinformation about the plan.

At the October Board meeting, the Trustees provided an additional forum for TSPP leaders to explain the plan and address APA's concerns. Sawyer stated that TSPP had no involvement in creating either the federation or the academy and has no control over either organization.

"The federation simply offers administrative services" for its member organiza-

please see ***Board*** *on page 40*

DB Presidents Describe Successful Membership, Outreach Efforts

While some district branches are having trouble retaining members and funding programs, others are gaining members and undertaking key outreach and advocacy initiatives, APA Board members learn.

Taking advantage of the Phoenix, Ariz., location of their meeting in October, APA Trustees invited the presidents of three Western district branches (DBs) to the meeting to discuss issues and challenges confronting their organizations and members.

Thomas Crumbley, M.D., president of the Arizona Psychiatric Society, said that his constituents are concerned about the "war chest" the state's psychologists are building for their eventual push to have state lawmakers grant them prescribing privileges. The DB has been proactive in strengthening its alliances with other concerned organizations to combat such an effort, he said, and already has promises of support from the state medical society.

Crumbley also described good news on the organizational front. The DB's finances are improving, he said, and, thanks to stepped-up outreach efforts, including a one-time dues amnesty, membership is beginning to increase. In addition, DB leaders are planning an "advocacy day" and are exploring formation of a political action committee.

Colorado Psychiatric Society President Cheryl Chessick, M.D., pointed out that her DB's membership is up to about 500, which represents more than 70 percent of the state's psychiatrists. Approximately 100 members are active on committees and in other DB activities. Among many community-outreach activities are periodic movie nights in which a psychiatrist leads a discussion about the film and an initiative to educate teenagers about mental health issues.

The Colorado DB is also active in a coalition of mental health advocacy groups known as the "mighty six," which has helped the DB get psychiatrists appointed to state-level committees that deal with mental health and patient care issues, Chessick noted.

Ellen Haller, M.D., president of the Northern California Psychiatric Society, which is celebrating its 50th anniversary this year, described a very active DB. Its members are planning an April conference titled "Sex and Psychiatry: The Role of Gender in Current Practice" and a two-day conference on pain management and end-of-life care. The latter is designed to meet California's requirement that physicians get 12 hours of continuing medical education on these topics.

Another group, Haller noted, is working on access-to-care issues, with psychiatrists having met with representatives of clinics, managed care organizations, and academic centers. The DB also plans to undertake an "aggressive marketing" program to convince nonmember psychiatrists to join. ■

Experts Advise on Advocacy Strategies

Michelle O. Clark, M.D. (center), of Los Angeles led a forum titled "Mental Health Advocacy: Get Involved" at APA's 2004 Institute on Psychiatric Services in Atlanta last month. At right is **Pat Strode,** interim director of the National Alliance for the Mentally Ill-Georgia, and at left is **Ellyn Jaeger** of the Georgia Mental Health Association. The forum focused on advocating for services and funding at the local level for children and adults with mental illness and included representatives from the Georgia state legislature and judiciary, as well as clinicians and psychiatric residents interested in advocacy.

Photo: Ellen Dallager

Become Active in APA And Make a Difference

BY RICHARD GRANESE, M.D.

As a recent psychiatry residency graduate and now a practicing psychiatrist, I realize that APA needs the assistance of the early career psychiatrists now, more than ever. We are facing a time in the practice of medicine when young physicians need to be active. I am not referring to the clinical aspect of seeing more patients, but to core principles of advocating for our patients and our profession. Our mentors and our senior colleagues are looking to us to lead our profession into the future. Passive moaning and complaining will be our downfall and can only harm our patients and our profession.

As psychiatrists, we are dealing with many serious issues that will affect how we practice and care for patients. We are dealing with state governments that allow clinicians who never went to medical school to prescribe medications. We are at a face-off with plaintiff lawyers who want to make money off our patients who take lifesaving psychotropic medications. We are fighting to gain and keep access to psychotropic medications for our indigent patients.

I am tired of hearing complaining about this and complaining about that. But why don't more of us get our hands dirty and do something about it? It may be easier to complain: it takes time and energy to do something. In an era of practicing medicine with increased clinical demands, increased nonbillable services, and decreased reimbursements, we are exhausted and frustrated. Upon completing residency, we are preoccupied with passing boards and establishing our practices. We don't want to do anything else, especially when the efforts seem daunting and goals unattainable. We are tired and want to have time for ourselves and families. We feel we need to decompress and blame everyone else. Isn't that what our society is teaching us—that it's everyone else's fault? But the truth is that it will be our fault if we don't act to make things better.

What can you and I do? We can become active in our district branch and in APA. You probably already have a good idea about the key issues that are affecting the practice of psychiatry. Educate other professionals and the community about psychiatry. Talk to psychiatrists who share similar interests and concerns. Write letters to the newspaper, communicate with the media, give lectures, and speak with your legislators. And don't give up. Perseverance and repeating your message are the only ways to influence change. Change is inevitable in health care. I encourage you to work to make the change benefit our profession. Don't sit there and think no one will listen. Don't wait for someone else to do it. There is no one else!

Early career psychiatrists must take a more active role. We are no longer residents to whom no one appears to listen. We have experience, energy, and enthusiasm. We must channel these qualities into more productive measures. We can help our profession; we can help our patients; we can find solutions. We have made sacrifices and worked diligently to get where we are. We must not let others spoil our great profession. It is our responsibility to prevent this.

Don't underestimate your influence as a psychiatrist and a leader. We must act now. Our level of commitment will be worth our efforts.

As for me, I have been active as an ECP within APA and my district branch on issues affecting patients in West Virginia. By becoming active in the West Virginia district branch, I have been able to help plan annual meetings and recruit speakers from APA to address grass-roots training on being an effective advocate. I have had the opportunity to encourage participation of residents by providing scholarships to them for CME presentations at the annual district branch meetings. I have continued to advocate for our patients by testifying on multiple occasions before the state Pharmacy and Therapeutics Committee for less-restrictive medication formularies. I have had the opportunity to visit with legislators at the state capitol to ask their support for a bill that would allow psychiatrists in West Virginia to use all psychotropic medications for our patients. These and many other such efforts are essential for our core mission of helping our patients. ■

Richard Granese, M.D., is the associate residency training director in the psychiatry department at West Virginia University in Charleston.

MCOs

continued from page 5

continuously during the six-month period following diagnosis. And just 20.3 percent received at least three visits with a clinician during the 12-week period following diagnosis, according to NCQA data.

Rates were even lower for Medicare and Medicaid patient (see chart on page 5).

The HEDIS instrument also measures the percentage of patients in a managed care plan who received follow-up treatment after hospitalization for mental illness.

According to the NCQA report, 74.4 percent of patients in the commercial market had a follow-up visit in the 30-day period following hospitalization last year. Among Medicare patients, 60.3 percent received a follow-up visit, while 56.4 percent of Medicaid patients received a follow-up visit during the 30-day period following hospitalization.

The report is posted online at <www.ncqa.org/communications/SOMC/SOHC2004.pdf>. ■

J-1 Visa Extension Likely To Become Law

The AMA and APA support passage of a bill renewing the J-1 visa waiver program, which allows international medical graduates to practice in areas where physicians are in short supply.

BY CHRISTINE LEHMANN

Legislation to renew the federal J-1 visa waiver program sailed through Congress last month and is headed for the president's signature.

APA and the American Medical Association supported passage of the Access to Rural Physicians Improvement Act of 2004 (HR 4453/S 2302), which renewed the program that expired on June 1 for two years, until 2006.

AMA Executive Vice President Michael Maves, M.D., wrote to House Speaker Dennis Hastert (R-Ill.) last month that "HR 4453 would help ensure that physicians are placed in appropriate settings to serve patients in underserved areas," according to an AMA press release.

Nearly every state participates in the J-1 visa waiver program in which noncitizen foreign-trained physicians who finish residency training are recruited to work in underserved rural and/or urban areas. About 20 million Americans live in areas where there are not enough physicians to meet their medical needs (*Psychiatric News*, August 2, 2002).

The waiver of the J-1 visa residency requirement is attractive to many international medical graduates (IMGs) who prefer to work in the United States after finishing their postgraduate training rather than return home for two years and apply for a different type of visa.

However, the original intent of the J-1 visa program, administered by the U.S. Information Agency (USIA) in the 1960s ,was to encourage educational and cultural exchanges between the United States and foreign countries in the post–cold war era.

IMGs could apply for nonimmigrant temporary status to obtain postgraduate medical training in the United States if they stated that they intended to return to their home countries after training.

"The goal was to give people training and experience in the U.S. they could use to benefit their home countries," the AMA stated in its June 2002 "Report on J-1 Visa Waivers."

But by the early 1970s, the J-1 visa policy was widely criticized for encouraging IMGs to immigrate to the United States, thus creating a brain drain of physicians from developing countries, according to the AMA report. In 1982 the AMA called for an end to preferential immigration policies for foreign medical graduates

Congress tightened preferential immigration policies and laws between 1976 and the early 1980s, according to the report.

In 1999 the USIA was merged with the U.S. Department of State, which reviews applications for waivers on a case-by-case basis. Physicians who came to the United States on a J-1 visa for graduate medical training could apply to have the requirement that they return to their home country waived if they anticipated persecution or exceptional hardship to a spouse or child. In addition, "an interested U.S. government agency can request the waiver because the visitors' acquired skills are in short supply within the U.S.," according to the report.

Several government agencies have served as interested parties requesting waivers, including the Department of Agriculture (USDA). Between 1994 and 2001, the USDA requested about 3,000 waivers. The USDA withdrew from the waiver program in late 2001, stating that it lacked the resources to conduct security background checks on all applicants following the September 11 attacks. The Department of Health and Human Services has attempted to fill the void left by the USDA and began reviewing J-1 visa waiver applications last year.

In 2002, 46 states participated in the federal J-1 visa waiver program.

The State Department continues to conduct security checks on all J-1 visa waiver applicants before it makes recommendations to the Bureau of Citizenship and Immigration Services in the Department of Homeland Security.

The "AMA Report on J-1 Visa Waivers" is posted online at <www.ama-assn.org/ama/pub/category/print/12882.html>. The J-1 visa waiver application and related information are posted online at <http://travel.state.gov/visa/tempvisitors_info_waivers.html>. ■

Drug Use

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ipated in binge drinking, which was defined as having five or more drinks on the same occasion at least once in the preceding 30 days.

Approximately 16 million people participated in heavy drinking, defined as having five or more drinks on the same occasion on at least five different days in the preceding 30 days. Each of the alcohol-related findings was similar to 2002 rates.

Almost a third of Americans aged 12 or older (70.8 million people) in 2002 and 2003 were current smokers. Young adults aged 18 to 25 had the highest smoking rates.

More information about the 2003 National Survey on Drug Use and Health is posted online at <www.oas.samhsa.gov/nhsda.htm#NHSDAinfo>. ■

GAO Questions VA's Ability To Provide More PTSD Care

The VA is working hard to make certain that soldiers returning from Iraq benefit from lessons learned since Vietnam.

BY KATE MULLIGAN

Will veterans returning home from Iraq receive prompt and effective treatment for their war-related mental health disorders?

Neither the Department of Veterans Affairs (VA) nor the Department of Defense (DoD) can provide a definitive answer, according to a recent report from the Government Accountability Office (GAO).

The report, released September 20, offered recommendations that would lead to improved data collection and coordination between the two governmental agencies.

The VA is working to implement the recommendations that call for the agency to combine data about veterans receiving treatment for PTSD at VA medical centers with data about those receiving treatment for PTSD at its veterans centers (Vet Centers).

(Vet Centers were established as entities separate from the medical centers because Vietnam veterans were reluctant to receive medical care for their war-related mental health disorders in a federal building.)

The combination of the data sets will give VA officials a better assessment of the current availability of treatment for PTSD and improved ability to project need for more services.

Officials at six of the seven VA medical facilities visited by GAO researchers reported that although "they are now able to keep up with the current number of veterans seeking PTSD services, they may not be able to meet an increase in demand for these services."

They also expressed concern because the VA had directed them to give priority for PTSD care to veterans returning from Iraq and Afghanistan. Follow-up care for veterans now receiving PTSD treatment could be delayed as much as 90 days, they fear.

Congress has appropriated $10 million for additional PTSD programs and outreach to returning veterans.

In July the *New England Journal of Medicine* published a study reporting the results of a survey administered to soldiers before deployment to Iraq and three to four months after return from combat duty in Iraq and Afghanistan *(Psychiatric News*, August 6).

According to lead author Charles Hoge, M.D., "The percentage of study subjects whose responses met the screening criteria for major depression, generalized anxiety, or PTSD was significantly higher after duty in Iraq (approximately 17 percent higher) than after duty in Afghanistan (11.2 percent) or before deployment to Iraq (9.3 percent)."

Hoge went on to report data that suggested the importance of outreach to veterans who need mental health services.

"Of those whose responses were positive for a mental disorder, only 23 percent to 40 percent sought mental health care. Those whose responses were positive for a mental disorder were twice as likely as those whose

responses were negative to report concern about possible stigmatization and other barriers to seeking mental health care."

Miklos Losonczy, M.D., Ph.D., co-chair of the Committee on Care of Veterans With Serious Mental Illness (SMI Committee), told *Psychiatric News* that the committee is concerned that military personnel might be reluctant to seek mental health care because of the potential impact on their careers and because of stigma.

The SMI Committee has recommended a memorandum of understanding between the DoD and the VA that would provide all returning military personnel with a "face-to-face discussion about possible reactions to stress. . . ." This discussion would educate returning veterans about PTSD and other mental health problems and would also offer an opportunity for early intervention when treatment appears necessary.

Losonczy said that the "increased likelihood of surviving direct hits and nearby explosions. . . has ramifications for the provision of mental health services."

It is likely there will be increased need for the provision of acute and chronic traumatic brain injury (TBI) rehabilitation. TBI, he added, is "associated with substantial behavioral changes," which require treatment.

Veterans surviving significant physical trauma will be at increased risk of depression, anxiety, and PTSD, Losonczy said.

Another problem is the "significant variability in access to services for veterans with all kinds of health care needs, including PTSD," he said.

The VA has acknowledged the problem of variability. In fact, "Achieving the Promise: Transforming Mental Health in the VA," a report released by the VA in December 2003, found, "Consistent access to mental health care in Community Based Outpatient Clinics (CBOCs) had not yet been achieved. Of 616 CBOCs in FY 2001, 258 had no mental health visits, and an additional 78 report that mental health care accounts for under 5 percent of their workload" *(Psychiatric News*, November 5).

Losonczy noted that during the past year there has been "substantial emphasis" on developing a mental health strategic plan that would identify areas "requiring enhanced services."

In his response to the GAO, VA Secretary Anthony Principi said that the VA had developed such a plan to "project demand by major diagnoses and provide capability for gap analysis."

He estimated that the plan would be completed by November 30.

Robert Rosenheck, M.D., director of the VA's Northeast Program Evaluation Center, told *Psychiatric News* that it is important to consider the current challenges in the context of the progress that the VA has made in its capability to treat war-related mental illness.

He said, "This is clearly a moment of uncertainty and apprehension. On one hand, research has demonstrated serious postdeployment mental health problems among some combat troops. On the other hand, the VA has more than 200 community-based readjustment counseling centers and more than 150 programs specializing in the treatment of PTSD at medical centers. The National Center for PTSD will conduct further research on problems of returning troops and provide educational support as new knowledge becomes available."

The report, "VA and Defense Health Care: More Information Needed to Determine if VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services" (GAO-04-1069), can be accessed online at <www.gao.gov/new.items/d041069.pdf>. ■

Suicide-Prevention Bill Gets Rapid White House Response

APA President Michelle Riba, M.D., M.S., praises President George W. Bush for signing a bill designed to prevent youth suicide, especially on college campuses.

BY CHRISTINE LEHMANN

A comprehensive suicide-prevention bill aimed at children and adolescents became law in October, only a month after Congress passed it.

APA President Michelle Riba, M.D., M.S., who attended the White House signing ceremony at the invitation of President George W. Bush, said, "We applaud the president and Congress for passing this new law to help address youth suicide—a major national health problem and the third-leading cause of death among persons aged 10 to 24 in the United States."

Riba continued, "The Garrett Lee Smith Memorial Act is a vital step forward in raising public awareness about suicide and in providing funds for suicide prevention and mental health services on college campuses."

The act, named after the late son of Sen. Gordon Smith (R-Ore.), who committed suicide last year while he was a college student, calls for early screening programs to identify mental illnesses in children and provide treatment referrals, training for community child care professionals, and creation of the Youth Interagency Research, Training, and Technical Assistance Center (*Psychiatric News*, October 15).

The law authorizes $82 million in grant money over three years to states, Indian tribes, and colleges and universities.

The legislation merges key provisions of two separate APA-supported bills. The bills were introduced by Sens. Christopher Dodd (D-Conn.), Mike DeWine (R-Ohio), and Jack Reed (D-R.I.), with considerable input from Smith.

APA Spurlock Fellow Harsh Trivedi, M.D., who works in Reed's office, helped draft the bill.

APA President Michelle Riba, M.D., M.S., is photographed with APA Spurlock Fellow Harsh Trivedi, M.D., who helped draft the Garret Lee Smith Memorial Act.

"APA commends the senators and particularly Sen. Smith for pushing the bill through Congress and obtaining the president's support," Riba said.

The Garrett Lee Smith Memorial Act, Public Law (PL) 108-355, can be accessed online at <http://thomas.loc.gov> by searching on the bill's name or PL number. ■

Some Prescriptions May Get Closer Monitoring

Congress is considering a bill that would mandate closer monitoring of prescriptions for controlled substances.

The House of Representatives, before it recessed last month, passed a bill that would establish a national reporting database for controlled substances.

The bill covers medications in Schedules 2 through 4 of the Controlled Substances Act (CSA). The CSA places all substances that are federally regulated into one of five schedules. The placement depends on the substance's medicinal value, harmfulness, and potential for abuse or addiction. Schedule 1 drugs are considered the most dangerous, with no recognized medical use, while Schedule 5 is reserved for the least dangerous drugs, according to the CSA legislation.

Rep. Edward Whitfield (R-Ky.), the bill's sponsor, said last year when he introduced the bill that it was intended to keep drug addicts from "doctor shopping" and to prevent prescription mix-ups, according to an October 1 article in *iHealthBeat*.

The National All Schedules Prescription Electronic Reporting Act of 2004 would require pharmacists to file a report within one week of dispensing a controlled substance.

The report is to include the name of the person who prescribed the drug, contact information for the person who received the drug, the drug's national drug code number, and the number of refills ordered.

Doctors and other clinicians would have access to the database information under certain circumstances, which would be determined by the secretary of Health and Human Services (HHS).

The legislation also calls for HHS to establish a uniform electronic format for

please see ***Prescriptions*** *on page 17*

Expert Gives Accounting Of HIPAA's Impact—So Far

HIPAA is a "floor": a clinician may be doing what the federal law says, but there may be state laws that require more.

BY MARK MORAN

The movement toward electronic medical records and the privacy and security requirements around electronic medical records embodied in the Health Insurance Portability and Accountability Act (HIPAA) are a revolution in the making for American medicine.

It is one that carries serious implications for confidentiality of medical and psychiatric records, said Richard K. Harding, M.D., in the lecture "The Psychiatrist's Duty to Protect Medical Privacy and Community Health" at APA's Institute on Psychiatric Services last month in Atlanta.

It also comes with a hefty price tag: the average hospital has already spent between $500,000 and $3 million to meet HIPAA requirements, said Harding.

Meanwhile, imminent technological advances associated with the move toward electronic medical records are likely to rush medicine into a brave new world. Prominent among these is a microchip that would be placed into a patient's triceps upon admission to the hospital, allowing the patient to be efficiently tracked throughout the hospital stay. The chip is expected to increase efficiency of record keeping and cut down on medical errors.

"It's coming," Harding said. "The changes are dramatic and about to explode."

Yet any number of uncertainties about how these changes will interface with medical ethics—and about how the privacy and security requirements in HIPAA will play out against countervailing forces claiming a right to information—remain to be clarified. Many of these uncertainties are destined for litigation, Harding said.

Some of them pit HIPAA requirements and the physician's traditional ethical responsibility to protect confidentiality against efforts to prevent terrorism. Harding emphasized that the U.S.A. Patriot Act allows federal agents to enter a physician's office without a warrant and demand the release of "tangible things" to protect against terrorism; moreover, the provision also comes with a gag order—a prohibition against telling anyone that the action has been taken.

"This is a potential abridgement of the First and Fourth amendments," Harding said. "That is the kind of thing that is going on that brings HIPAA up against very powerful forces. And it is something that we have to be constantly vigilant about."

Harding is a professor and chair of the department of neuropsychiatry and behavioral science at the University of South Carolina School of Medicine in Columbia, S.C. He served as president of APA for the 2001-02 term and is now a member of the APA Corresponding Committee on Confidentiality. He has been a member of the National Committee on Vital and Health Statistics of the Department of Health and Human Services (HHS) since 1998.

Harding placed the movement for electronic medical records against the backdrop of rising health care costs, diminishing access, and the still-persistent demand among Americans for the latest technological and pharmacological innovations and freedom of choice of physicians.

Within this environment efficiency has become everyone's fall-back answer for how to control costs—and what efficiency has come to mean, aside from eliminating fraud and abuse, is electronic medical records. In fact, a staple of the health care plans of both candidates in the U.S. presidential contest was electronic medical records, Harding noted.

He added that an indication of the momentum behind electronic medical records is the fact that National Health Information Technology Coordinator David Brailer, M.D., Ph.D., was named the most powerful person in health care today in a survey of health care leaders by the magazine *Modern Healthcare*.

Brailer was appointed to the position earlier this year by HHS Secretary Tommy Thompson. The position was created at HHS by President George W. Bush to coordinate the nation's health information technology efforts.

Yet Harding reminded session participants that HIPAA, passed in 1996, originally had nothing to do with privacy or security of medical records, but was intended to provide for portability of health insurance between job changes.

Without any hearing or debate on the floor, said Harding, "something was tacked onto the bill" late in the process. "That something was called 'administrative simplification.' "

Administrative simplification meant three far-from-simple things: a national health information infrastructure, federal privacy protections, and a unique national patient identifier. The latter was to be a biologic marker or alphanumeric identifier—not a person's Social Security number—that would serve as a personal identifier within the national health information infrastructure.

The identifier was one item that, while not eliminated, was put in abeyance by an amendment supported by APA that prohibited the federal government from providing funding for the unique identifier, Harding said.

HIPAA was groundbreaking, providing the first federal standards for privacy, confidentiality, and security of individually identifiable health information. Health plans, physicians and other providers, and health clearinghouses—those entities, for instance, that format and process physicians' *CPT* codes for insurance companies—must comply with the standards.

please see ***HIPAA*** *on page 37*

Watchdog Agency Questions Benefits of Medicare PPOs

The GAO states that CMS "exceeded its statutory authority" when it allowed 29 health plans to pay for certain services only if beneficiaries obtained those services from network providers.

BY MARK MORAN

Preferred provider organizations (PPOs) may not be the answer to reforming Medicare that the Bush administration hopes them to be.

That's one finding in a Government Accountability Office report titled "Medicare Demonstration PPOs: Financial and Other Advantages for Plans, Few Advantages for Beneficiaries."

The GAO report examined demonstration projects launched by the federal Centers for Medicaid and Medicare Services (CMS) that were designed to attract PPOs to Medicare+Choice, the program that provides beneficiaries a choice of private plans. The report found that, contrary to expectations, the demonstration projects attracted relatively few beneficiaries.

The GAO also stated that CMS "exceeded its statutory authority" when it allowed 29 of 33 of the health plans in the Medicare PPO Demonstration to pay for certain services only if beneficiaries obtained those services from network providers—a violation of provisions governing the health plans' participation in Medicare.

"In general, beneficiaries in Medicare PPO Demonstration plans who received care from non-network providers for these services were liable for the full cost of their care," the GAO wrote. "Examples of such services include skilled nursing and home health, which are covered under fee-for-service Medicare, and dental care and routine physical examinations, which are not covered under fee-for-service Medicare."

A goal of the Bush administration has been to increase beneficiary enrollment in Medicare+Choice. Though PPOs are more prevalent than any other type of health plan in the private insurance market, only six PPOs had contracted to serve Medicare beneficiaries in Medicare+Choice as of 2003.

To attract more PPOs to the program—particularly beneficiaries currently enrolled in the fee-for-service plan—two demonstration projects were started that included a total of 34 PPOs.

But the GAO report stated that the PPO demonstration projects attracted relatively few enrollees from the fee-for-service plan and did "little to expand Medicare beneficiaries' access to private health plans in 2003."

According to the report, only about 98,000 of the 10.1 million eligible beneficiaries living in counties where demonstration PPOs were available enrolled in the demonstration projects. "Further, although one of the goals of the Medicare PPO Demonstration was to attract beneficiaries from FFS [fee-for-service] Medicare and Medigap plans, only 26 percent of enrollees in Medicare PPO Demonstration plans came from FFS Medicare, with all others coming from Medicare+Choice plans."

The GAO recommended that CMS instruct plans in the Medicare PPO Demonstration to provide coverage for all plan services furnished by any provider that is authorized to provide Medicare services and accepts the plans' terms and conditions of payment.

CMS Administrator Mark B. McClellan, M.D., Ph.D., responded that the agency would seek to implement the GAO recommendations and is working with PPO demonstration plans to ensure that they comply with the provisions that govern their Medicare participation.

But in a letter to GAO after reviewing the report, McClellan also expressed concern about the "tone" of the report, including the title of it, which he called "misleading, unfair, and not supported by the information presented in the report itself." He reiterated the administration's optimism about PPOs. "We believe beneficiaries benefit substantially from increased access to the PPO model and will, in the long run, be better off for the availability of these types of plans in the new Medicare Advantage program."

McClellan also said criticisms about enrollment in a demonstration project overlook the experimental nature of demonstration projects.

"It is important to note that the PPO Demonstration is just that, a demonstration," McClellan wrote. "The financial arrangements developed for the project were intended to encourage plans to participate in this experiment, and they should be viewed as a first step in the development of better ways to establish partnerships between the Medicare program and private plans for the benefit of Medicare beneficiaries."

The GAO report is posted online at <www.gao.gov/new.items/d04960.pdf>. ■

WAXMAN GIVEN APA*PAC* SUPPORT

APA past president **Daniel Borenstein, M.D.** (right), meets with Rep. **Henry Waxman** (D-Calif.) in Waxman's home district, where Borenstein resides. Waxman is a key member of the House Energy and Commerce Subcommittee on Health and a long-time ally of APA. The visit is part of an ongoing program at APA—through its political action committee, APA*PAC*—in which APA members educate federal and state legislators and policymakers about mental health issues.

More information on APA*PAC *is posted in the Members Corner section of APA's Web site at <www.psych.org/members/pub_pol_adv/apapac/index.cfm>.

As Medicaid Grows, So Do Budget Woes

The importance of Medicaid, a 2,000-pound gorilla that shapes public health care delivery and dominates states' budgets, continues to grow.

BY KATE MULLIGAN

Further efforts to contain the growing costs of Medicaid appear likely, according to an annual survey released in October by the Kaiser Commission on Medicaid and the Uninsured (KCMU).

"The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005" reported survey results showing that all 50 states and the District of Columbia implemented Medicaid cost-control strategies in Fiscal 2004, and all plan new actions for Fiscal 2005.

Health Management Associates conducted the survey for the KCMU in July and August 2004, at the end of most states' 2004 fiscal year.

The most popular actions continue to be efforts aimed at controlling the costs of prescription drugs and freezing or reducing payments to those who provide medical services (see chart).

The KCMU hosted a briefing last month about that survey and a related report, "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families."

Diane Rowland, the KCMU's executive director, reminded the audience of key factors that have put pressure on states' Medicaid budgets.

"[There has been] a great increase in the number of people who are below the poverty level since 2000," she said.

That increase is 5.6 million Americans, according to Rowland, with an increase of 2.1 million Americans in the "near poor" category.

Percentages of people who are uninsured are increasing, and those with employer-sponsored insurance are decreasing.

The report's lead author, Vernon Smith, Ph.D., emphasized the increasing importance of Medicaid in terms of health care delivery. He said it is the "largest, single public health program in America today" and accounts for about 17 percent of all health care spending in the country.

"Medicaid [accounts for] a significant part of hospital spending and overall spending for physicians [and] plays a special role in long-term care, constituting about half of all spending for nursing home [care] and about 18 percent of all spending for prescription drugs."

He added that Medicaid is the "largest single purchaser of prescription drugs in the country."

Selby Jacobs, M.D., chair of APA's Committee on Public Financing of Psychiatric Services, told *Psychiatric News* that Medicaid appears to be of increasing importance to psychiatrists, as well as to the public mental health system.

He cited information from the New Freedom Commission on Mental Health that Medicaid is the largest payer of mental health services in the country.

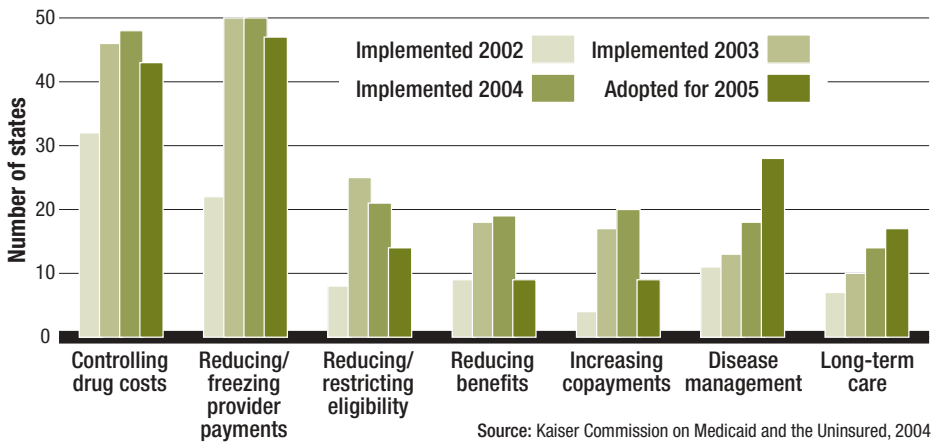
Jacobs said that data analyzed by his committee for the period 1996-2002 showed a "slow, overall growth" of 14 percent to 17 percent in the percentage of psychiatrists' caseload paid for by Medicaid. Although that change is not statistically significant, subgroups of psychiatrists report Medicaid as a "substantial payer" of their caseload.

Perhaps even more important, said Jacobs, is the fact that Medicaid is of growing importance to psychiatrists who are out of residency less than a decade. That group showed an increase in the percentage of their caseload attributable to Medicaid from

please see ***Medicaid*** *on page 40*

Putting the Brakes on Medicaid Spending

All 50 states and the District of Columbia have taken steps to control Medicaid costs. The most common cost-containment strategies are shown below.



Source: Kaiser Commission on Medicaid and the Uninsured, 2004

Juvenile Offenders Rarely Get Substance Abuse Treatment

A new report from the National Center on Addiction and Substance Abuse calls for an urgent overhaul of the juvenile justice system.

BY CHRISTINE LEHMANN

A comprehensive analysis of substance abuse among juvenile offenders by Columbia University's National Center on Addiction and Substance Abuse (CASA) reveals that in 2000, when the most recent detailed data became available, 80 percent of adolescents in state juvenile justice systems had abused alcohol or drugs.

The researchers defined their criteria for substance abuse as a youth being under the influence of alcohol or drugs while committing the offense, testing positive for drugs, being arrested for committing an alcohol or drug offense, admitting to having substance abuse or addiction problems, or sharing some combination of these characteristics, according to a CASA press release announcing the findings.

In addition, drug or alcohol abuse among youth was implicated in 64 percent of violent offenses, 72 percent of property offenses, and 81 percent of assaults, vandalism, and disorderly conduct, CASA pointed out.

The 177-page report, "Criminal Neglect: Substance Abuse, Juvenile Justice, and the Children Left Behind," also found that while 1.9 million of the 2.4 million juvenile arrests in 2000 involved drug or alcohol abuse, only 4 percent of those with substance abuse problems received treatment for them while in the juvenile justice system.

This "criminal neglect," CASA noted, contributed to recidivism as these untreated youngsters aged; at least 30 percent of adults in prison for felony crimes were incarcerated as juveniles, according to CASA.

Joseph Califano Jr., CASA's chair and president and a former U.S. Secretary of Health, Education, and Welfare (the predecessor of the Department of Health and Human Services), said in the press release, "We are releasing [these juveniles] without attending to their needs for substance abuse treatment and other services—punishing without helping them to get back on track."

Califano observed that there are 51 juvenile justice systems in the United States, with no national standards for recommended practices or accountability. He called for "a complete overhaul of the juvenile justice system to assure that each child receives a comprehensive assessment of needs, substance abuse treatment, and other appropriate services."

The report also calls for expanding federal grant programs for juvenile justice and delinquency prevention and making the grants conditional on the states' efforts to reform their juvenile justice systems. Other recommendations urge these actions:

- Training all juvenile justice staff, including juvenile court judges, law enforcement personnel, and other court staff, in how to recognize and deal with substance-using offenders.
- Making treatment, health care, education, and job training programs available to children in juvenile justice systems.
- Creating a model juvenile justice code to set a standard of practices and accountability for states in handling juvenile offenders.

Shortly after the CASA report was released in October, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) announced $23.3 million in grants to support substance abuse treatment and related services for juveniles and young adults returning to the community from incarceration.

"By helping our youth avoid drugs and alcohol, we can help prevent them from committing crimes and returning to prison," Health and Human Services Secretary Tommy Thompson said in a press release.

SAMHSA Administrator Charles Curie commented, "The grants will be used to form community partnerships that will plan, develop, and provide services in the community to treat substance abuse and provide other services."

Curie added, "We will build on community ties to keep these young people away from drugs and moving into training or jobs that can anchor them and lead to a life free from drugs and free from crime."

The CASA report, "Criminal Neglect: Substance Abuse, Juvenile Justice, and the Children Left Behind," is posted online at <www.casacolumbia.org/pdshopprov/shop/item.asp?itemid=73>. ■

Prescriptions

continued from page 14

reporting and sharing drug data.

The bill, HR 3015, authorizes federal appropriation of $25 million each in Fiscal 2006 and 2007, and $15 million in each of the following three fiscal years to help pay for the databases.

The bill has been sent to the Senate, where it awaits action.

The National All Schedules Prescription Electronic Reporting Act of 2004 can be accessed online at <http://thomas.loc.gov> by searching on the bill name or number, HR 3015.

The Controlled Substances Act is posted online at <www.usdoj.gov/dea/agency/csa.htm>. ■

Another Residency Program Joins APA's 100% Club

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

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

A photo of each program that joins the 100% Club will be turned into a poster and mailed to every medical school in the United States and Canada to encourage medical students to join APA.

Commented Meredith Alden, M.D., the Utah program's training director and president of the Utah Psychiatric Association, "In addition to our 100 percent membership in APA, the University of Utah psychiatry residency program has a pass rate of more than 90 percent for the American Board of Psychiatry and Neurology exams. We are proud of our excellent training program. Please visit at <www.med.utah.edu/psychiatry>."

Back row, from left: Jon Caldwell, M.D., Bill Bunn, M.D., Chris Gross, M.D., Greg Baca, M.D., Chris Vinegra, M.D. Second row from top, from left: Dawn Stewart, M.D., Laura Markley, M.D., Brent Fletcher, M.D., John Thatcher, M.D., Jennifer Gordon, M.D. Third row from top, from left: Katie Sherry, M.D., Caroline Merveille, M.D., Kristi Kleinschmit, M.D., Lee Wheeler, M.D. Front row, from left: Bernard Grosser (chair), M.D., Sajid Faizi, M.D., Noel Schenk, M.D., Rene Valles, M.D., Jenny Starr, M.D., Meredith Alden, M.D. (training director and president of the Utah Psychiatric Association).

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

Canadian

continued from page 1

on medications because the labels are not in their native language, said Jose Silveira, M.D., also of Toronto Western Hospital, whose mental health clinic serves about 280,000 Portuguese-speaking people.

Patients from other cultures may have unconventional ideas about the causes of mental illnesses. One Inuit (Eskimo) patient with schizophrenia told Quebec psychiatrist Marie-Eve Cotton, M.D., that he wondered whether his "voices" meant that he was an Inuit shaman—that is, had the power to heal. Some Christian Inuits believe that mental illness is due to possession by the devil and that exorcism can heal it.

Not a few ethnic patients are troubled by identity, a concept that has to do with where they come from and where they are going, their social position, experiences that have affected their lives, and their perspective on the world. Trying to help ethnic patients redefine themselves is not easy, Kirmayer conceded.

Nor is it easy to help patients from other cultures deal with their social predicaments. Sometimes people of various ethnic backgrounds make an appointment with Andermann not because they are mentally ill, but because they have a social need, such as housing, and hope that she will provide them with a letter of recommendation.

Migration has not been found to be a risk per se for mental illness, but some factors associated with migration, such as a drop in socioeconomic status, are. "It is not unusual in Toronto to find physicians driving cabs," said Kussin. One can't help but wonder how they're faring mentally, he said.

Morton Beiser, M.D., a professor of psychiatry at the University of Toronto, and his colleagues studied Southeast-Asian refugees who were admitted to Vancouver from 1979 to 1981. The researchers found that unemployment in this group could lead to depression, as well as that depression could lead to unemployment.

In contrast, many people in this group were not depressed, purportedly because they concentrated on the present and repressed many aspects of their lives in their home country. Thus, repressing the past may be one way that refugees cope with their precarious situation and are able to find their way in their new country.

One reason to think that this is the case is that when Beiser and his team followed the fate of the Vancouver refugees from 1981 to 1991, they found that the refugees had lower rates of depression and anxiety than Canadians in general, that the refugees had done "exceptionally well" regarding employment, and that the refugees' stories were "generally happy ones."

Some ways in which Canadian psychiatrists can help people of various cultures achieve "happy endings" were also discussed at the CPA meeting.

One is to conduct a good cross-cultural patient interview. Adam Quastel, M.D., a University of Toronto psychiatrist who works with peoples who were in Canada before the arrival of European settlers, determines what language or languages patients speak and whether an interpreter is needed. He then asks patients what brought them to see him and why (this way he constructs their stories and also demonstrates that he is interested in them) and asks what their current cultural identification is (which helps him decide how he is going to treat them).

Laurence Kirmayer, M.D.: The more psychiatrists know about the circumstances of where immigrants come from, the better they can help immigrants redefine themselves.

Psychiatrists can also assist immigrants in establishing a new identity. The more you know about the circumstances of where they come from, the better you can help them redefine themselves, Kirmayer advised.

One consideration is the cytochrome P450 enzymes, which are crucial for metabolizing psychotropic drugs and can vary dramatically among ethnic groups. There are now labs in both Canada and the United States that test for differences in the genes that make these enzymes, and such tests can reveal whether the patient can metabolize a particular drug, Joseph Sadek, M.D., a Dalhousie University psychiatrist and psychopharmacologist, reported. "This is a new direction in psychopharmacology service," he added. He and his colleagues have also "used the tests successfully" in their clinics, he told *Psychiatric News*.

A psychiatrist's being open and nonjudgmental about unconventional treatments may benefit patients from certain cultures. If Inuit patients want to talk about shamanism to understand the voices they hear, Cotton is open to it. But if they want to talk with her about serotonin, that is fine, too. "That is their choice, and the healing factor," she said. She also tells them about the medications she can offer them, but adds that if they want to go to a shaman or a priest for help, she will not be angry at them for doing so.

In fact, unconventional treatments may help such patients. Cotton had an Inuit patient who had been sexually abused and who sought exorcism as a means of healing psychologically. After the exorcism she got better and has remained well for three years. "It left me quite speechless," Cotton admitted.

All in all, Canada is a country not just of incredible diversity, but of considerable

Marie-Eve Cotton, M.D., a Quebec psychiatrist, has worked with the Inuit peoples for six years.

tolerance. Thus, if any psychiatrists can offer some good suggestions on how to be culturally competent, it is probably Canadian psychiatrists. "We are uniquely positioned to make a contribution globally," Kirmayer contended. ■

Government Seeks Strategies To Reduce Obesity Epidemic

Although some strategies to reduce obesity among American youth have led to positive results, more research—especially behavioral research—on ways to prevent childhood obesity is urgently needed.

BY JOAN AREHART-TREICHEL

American youngsters are not escaping the fattening of America, which is causing not just a major public health crisis, but a resizing of clothes, public seats, ambulances, and even coffins. In fact, childhood obesity is reaching epidemic proportions in all 50 states.

Thus Congress and the Centers for Disease Control and Prevention asked the Institute of Medicine to produce a report on the childhood obesity epidemic and how to counter it. That report has now been published.

The following are some of the findings and recommendations in the 461-page report, especially information on the psychological difficulties that overweight children experience and efforts to change their behaviors so that they will lose weight.

• American children from lower socioeconomic strata, from the South, and from certain ethnic groups appear especially susceptible to obesity.

• Results from studies of the emotional well-being of obese children are difficult to summarize given differences in subjects and outcome measures used, among other factors. Nonetheless, findings generally indicate a link between obesity and low self-esteem. However, such low self-esteem appears to be more prevalent among girls than among boys, and more common among Hispanic and white girls than among African-American ones.

• Stigmatization of obese children appears to have increased over the past 40 years. Thus, there is a need to reduce negative attitudes toward overweight youth and the teasing that results.

• Scientific efforts to reduce obesity among American youth have had varying results. For example, in one study cited in the re-

please see ***Obesity*** *on page 34*

Ignoring Asian Patients' Values Jeopardizes Treatment Success

To successfully engage Asian-American patients who need mental health care, one expert advises clinicians to set treatment goals that are closely aligned with values that are vital in those patients' culture.

BY EVE BENDER

Although Asian Americans have some of the highest suicide rates in the United States, many are reluctant to access mental health services due to stigma and shame. Those who do seek treatment must often wait for months before sitting down with a psychiatrist or mental health practitioner.

Henry Chung, M.D., illuminated the problems facing Asian Americans with mental illness at a meeting whose theme was "Overcoming Stigma in Asian American Mental Health" in New York City in October. The meeting was sponsored by the New York Coalition for Asian American Mental Health, an organization established in 1988 to improve the quality of mental health care services available to Asian Americans in the New York City area.

"Are we not restigmatizing Asian-American patients again by telling them, 'I know you need help, but you must wait three to six months before you can get care?' " asked Chung, who is a clinical associate professor of psychiatry at New York University School of Medicine and senior director of research and strategic management at the Charles B. Wang Community Health Center in New York.

Henry Chung, M.D.: Despite high rates of mental health problems among Asian Americans, mental health services are underutilized among this population.

One mental health problem that must be dealt with immediately is suicide, and Asian-American women commit suicide at higher rates than women from other ethnic groups in the United States, Chung said.

In data compiled from 1990 to 2001 by the National Center for Health Statistics of the Centers for Disease Control and Prevention, the suicide rates among older Asian or Pacific Islander (API) women consistently topped those for elderly women from other ethnic groups.

For example, in 1995, there were 8.6 suicides per 100,000 people among API women over age 65, compared with 5.8 suicides for age-matched white women and 2.1 suicides for age-matched African-American women. (Suicide rates for Latino women over age 65 were listed as unreliable due to the low frequency with which such events were reported.)

Elderly Asian patients also had the highest rates of death ideation—passive death wishes—and suicidal ideation in one primary care study, according to Chung.

In the Primary Care Research in Substance Abuse and Mental Health for the Elderly study published in 2002, psychiatrist Stephen Bartels, M.D., examined more than 2,000 primary care patients aged 65 and older with depression, anxiety, and risky alcohol use. He found that Asians had the highest rate of death ideation (37.8 percent) when compared with Latinos (34.8 percent), whites (27.2 percent), and blacks (21.76 percent), and the highest rate of suicidal ideation (18.9 percent) when compared with whites (13.5 percent), blacks (5.3 percent), and Latinos (5 percent).

"These are our elderly folks walking around in the community," Chung said. "These are your parents and my parents."

Depression, in particular, often goes unnoticed in the primary care setting, he noted.

Chung conducted a study of 252 Asian and Latino patients entering a public ambulatory medical clinic over a six-month period and found that 41.6 percent of the Asian patients had symptoms of depression, yet only 23.6 percent of them were identified as such by primary care physicians working in the clinic.

"The problem was not that we had bad doctors," Chung remarked, "but that these patients did not come in complaining of psychological problems—they didn't say they were worried or sad."

Asian patients with depression instead tend to complain of backaches, headaches, or other somatic complaints, he said, "and if they don't volunteer information about their depression, it can be difficult to recognize it."

Chung also emphasized the impact of stigma on Asian Americans with mental illness. Many are hesitant to acknowledge symptoms of mental illness because such admissions may damage the reputation of the person's family in their community.

As a result, utilization rates of mental health services are low among Asian Americans.

For instance, Chung cited data from a study conducted by Sheying Chen, Ph.D., showing that although Asian Americans comprised 9.1 percent of the San Diego County population, they only represented 3.6 percent of those receiving mental health services in the county.

Removing cultural and language barri-

please see ***Asian Patients*** *on page 37*

'Tremendous Stigma' Keeps Some Asians From MH Care

By allying themselves with spiritual leaders and family members of patients of South-Asian descent, psychiatrists have a better chance to help these patients to recover from mental illness.

BY EVE BENDER

When people of South-Asian descent begin to experience mental health problems, a psychiatrist or mental health professional is usually among the last ones to whom they will turn for help.

The majority first consult a family member or a religious elder, explained Nalini Juthani, M.D., a professor of clinical psychiatry at the Albert Einstein College of Medicine in New York and an examiner for the American Board of Psychiatry and Neurology.

Juthani, who is also a member of the *Psychiatric News* Editorial Advisory Board, appeared at the meeting, "Overcoming Stigma in Asian-American Mental Health" in New York in October to discuss issues impacting South Asians who have immigrated to the United States from countries such as India, Pakistan, and Sri Lanka.

"Identification of mental illness in this population is a slow process because their families tolerate, rationalize, and deny distorted thinking, depression, and anxiety," Juthani explained.

Only when mental health problems significantly interfere with a person's functioning at school or work do they come to the attention of a family member, a trusted elder in the community, or a mental health clinician.

People of South-Asian descent "tend to conceal the pathology and suffer quietly," Juthani noted.

"Mental illness carries tremendous stigma, which prevents patients and families from coming forward for treatment," she said.

South Asians living in the United States may cope with their distress by becoming deeply involved in religion, using homeopathic treatments, or Ayurvedic medicine, which Juthani defined as an "ancient Indian science of life that focuses on the balance between mind, body, and spirit."

Ayurvedic medicine teaches that each person has a certain body type with its own remedies to restore the balance between the three domains, she said.

Nalini Juthani, M.D.: Among South-Asian immigrants, "mental illness carries tremendous stigma that prevents patients and families from coming forth for treatment."

According to Ayurveda, mental illness falls into two categories.

Nija, or endogenous type, causes symptoms such as inappropriate behavior, anger, excitement, and violence and is usually treated with a variety of Ayurvedic medicines, a restricted diet, massage therapy, and reassurance.

Agantu, the exogenous form of mental illness, is caused by the wrath of gods or ancestors or by possession by various spirits, and it warrants the same treatments used for Nija, Juthani noted.

If the person in distress is Hindu, he or she may believe the symptoms are caused by bad karma from this or a previous life, she explained.

Juthani also addressed the all-important role of family in South-Asian culture and expectations South Asians have of psychiatrists who treat a family member with mental illness.

For instance, psychiatrists should be aware that South-Asian families often do not accept theories relating to the genetic basis of mental illness, Juthani said, because "hereditary aspects of the illness bring shame to the entire family," and as a result, marriage proposals to the patient's siblings may be jeopardized.

Family members and patients, however, accept a condition that "can be accounted for as short-lived and curable" and expect that the psychiatrist will prescribe medicines to relieve the symptoms of mental illness, Juthani said.

In terms of psychotherapy, short-term cognitive-behavioral therapy is generally better accepted by South-Asian patients and their families than are longer forms of psychotherapy.

Ideally, Juthani noted, psychiatrists and other mental health clinicians should "combine traditional forms of healing such as yoga and meditation with Western modalities of mental health treatment. A clinician's approval of such faith-based practices and willingness to collaborate with spiritual leaders and family members is the best way to achieve a positive outcome," she said. ■

Professional News

NAPHS Directory

The National Association of Psychiatric Health Systems (NAPHS) has published its *2005 Membership Directory*. The directory is a comprehensive referral resource providing information on the nation's behavioral health care systems. The NAPHS directory is intended to help those who must quickly identify sources of help for individuals with psychiatric and addictive disorders. The directory includes the name, address, phone/fax numbers, and officers of each behavioral health system. The facilities operated by each system are also listed. To help locate services in particular states, a geographical listing of facilities is included.

Copies of the directory may be ordered from NAPHS for $35 (shipping and handling included) by calling (202) 393-6700. An order form is posted on the NAPHS Web site at <www.naphs.org/news/documents/orderformmembershipdir05_000.pdf>. ■

Ethnicity Shouldn't Determine Dosage Decisions

When treating Asian patients with psychotropic medications, it is always best to determine dose based on individual response and avoid generalizations based on ethnicity, an expert advises.

BY EVE BENDER

In practice settings around the world, it is not uncommon for psychiatrists to prescribe Asian patients low doses of psychotropic medication with the understanding that Asians metabolize these medications at slower rates than patients of other ethnicities.

As a result of this practice, however, these patients may not be receiving adequate treatment, said James Chou, M.D., an associate professor of psychiatry at New York University School of Medicine.

Chou appeared at the meeting "Overcoming Stigma in Asian American Mental Health," with Ramaswamy Viswanathan, M.D., to discuss issues related to the psychiatric treatment of Asians. The meeting was held last month in New York.

Culture May Be Reflected in Symptoms

While treating Asian patients with mental illness, psychiatrists may encounter some of the following culture-bound syndromes, according to Ramaswamy Viswanathan, M.D.:

- **Ainu** occurs in Japanese women and includes startle responses, automatic response to commands, and utterances of obscenities.
- **Hsieh-Ping** is a trancelike state in which Chinese men believe they are possessed by dead relatives.
- **Koro** is a panic state experienced by Southeast-Asian men who believe their penis is shrinking.
- **Hwa-Bung** affects people from Korea and includes symptoms that overlap with the *DSM-IV* criteria for major depression, including dysphoric mood, irritability, anxiety, and difficulty concentrating.
- **Dhat** syndrome occurs in Indian men and is characterized by the belief that semen is lost in the urine, resulting in a depletion of physical and mental energy.

While it is true that some people of Asian descent, as well as those from other ethnic groups, may not metabolize psychotropic medications at the same rate as Caucasians, there is no basis for automatically prescribing half the recommended dosage to a patient because he or she is Asian, Chou said. "You have to base the drug dosage on individual response and avoid generalizations based on ethnicity."

James Chou, M.D.: The practice of prescribing reduced doses of medication to Asian patients may be leading to inadequate treatment of their mental illness.

Chou explained that people belonging to certain ethnic groups produce lesser amounts of enzymes, such as CYP2D6, which break down toxins in the body. This can result in higher blood levels of certain psychotropic medications and more side effects for the patient.

However, he cautioned, practitioners can't judge how quickly a patient will metabolize the medications based solely on the color of their skin or the country in which they were born.

A number of studies from the 1970s through the 1990s show that Asians receive lower doses of benzodiazepines, mood stabilizers, and antipsychotic medications than do white Americans, Chou said.

For instance, Teruo Okuma, M.D., and other researchers found that therapeutic dosages of chlorpromazine and lithium were different in Japan from those in Western countries in the early 1980s, with Japanese patients receiving lower dosages.

Ching-Piao Chien, M.D., reported in 1993 that Asian and Hispanic immigrants who had been in the United States less than five years received lower dosages of medication than those who had been in the country longer than five years.

Chou reviewed several studies investigating Asian patients' responses to a number of psychotropic medications but warned that in the majority of the studies small sample sizes mitigated the impact of any conclusions.

For instance, Keh-Ming Lin, M.D., M.P.H., and colleagues found in 1989 that when they administered fixed doses of haloperidol to 13 Caucasian and 16 Asian patients with schizophrenia, the Asian patients had a 10 percent to 15 percent higher

please see ***Dosage*** *on page 37*

BMS ABILIFY
PBW

Analyst Heals Divide Between Eastern, Western Mind Sets

Psychoanalysis is today more willing to challenge some of its own notions, once considered sacrosanct, making the field far better prepared to develop an international language and perspective.

BY MARK MORAN

Is a dialogue possible between psychoanalysis, with its explicitly Western language and assumptions, and the Eastern cultures of the world? The chances are good for at least a start if the psychoanalyst doing the talking is Salman Akhtar, M.D.

In his lecture last month at APA's Institute on Psychiatric Services (IPS) in Atlanta titled "Psychoanalysis and Eastern Cultures: Adversaries or Allies?" Akhtar held out the promise of something like a rapprochement between the ancient cultures of the East and the depth psychology of the West.

Photo: Ellen Dallager

Salman Akhtar, M.D.: "To take a theory developed from the observation of little white children from upper-middle-class Manhattan and generalize to all the world is a problem."

Akhtar received APA's Kun-Po Soo Award, which recognizes an individual who has made significant contributions toward understanding the impact and import of Asian cultural heritage in areas relevant to psychiatry.

In an address salted with trademark good humor, wit, and poetry, Akhtar offered a critique of tendencies within psychoanalysis, and within the cultures of the East, that have stymied communication between the two.

In particular he cited an early, antiquated emphasis within psychoanalysis on the body and anatomy as masters of the mind, an emphasis that has caused it to speak in a language that falls on Eastern ears as lewd and obscene. Moreover, he said the effort to impose developmental theories derived from empirical observations in narrowly Western contexts on non-Western subjects can have only disastrous results.

Akhtar said certain Eastern traits that have been considered inimical to psychoanalysis and to the Western spirit generally—silence, inactivity, and acceptance of death as part of life—are already being incorporated into, and enriching, psychoanalytic theory and practice.

In turn, Akhtar said Eastern cultures should welcome Freud's admonition to not be afraid of one's thoughts and should relinquish the propensity to seek violent retribution against those who dare to say or write what is considered unthinkable or sacrilegious. He also said Eastern societies need to develop a vocabulary for talking about sexual and anatomical functions that is not considered obscene by their own people.

"I think there is a lot of scope for dialogue and enrichment, provided the Eastern peoples give up their defensiveness and provided the Western people give up their colonial tendencies," he told his audience.

Akhtar may be especially suited to open a discourse between East and West. Born in Lucknow, India, in 1946, he came to the United States in 1973. He trained in psychiatry at the University of Medicine and Dentistry of New Jersey in Newark, the University of Virginia in Charlottesville, and the Philadelphia Psychoanalytic Institute. Today, he is a lecturer in psychiatry at Harvard Medical School, a professor of psychiatry at Jefferson Medical College, and a training and supervising analyst at the Philadelphia Psychoanalytic Institute.

Akhtar is the author of numerous scientific papers and books, as well as six volumes of poetry. He is the recipient of the Margaret Mahler Literature Prize and the American Psychoanalytic Association's Edith Sabshin Award. He is also a scholar in residence at Interact Theater Company in Philadelphia.

Akhtar said the Kun-Po Soo Award and lecture is itself a sign of a developing dialogue within psychiatry between East and West. And he added that psychoanalysis is today more willing to challenge some of its own notions, once considered sacrosanct, making the field far better prepared to develop an international language and perspective.

"Things are much more open today," he said. "This talk could not have been given by a psychoanalyst some years ago."

Akhtar noted that at least four separate and distinct concepts are implied in psychoanalysis: a theory of mental functioning, models of development that vary depending on the school of psychoanalysis to which one adheres, concepts of psychopathology, and the technique and practice of analysis with a patient.

Of these, only the theory of mental functioning—conscious and unconscious forces, projection, internalization, regression, among all the numerous other terms for how the mind operates—is universally applicable across cultures and ethnic groups.

The other aspects of psychoanalysis are culture bound and encounter difficulty when an attempt is made to transport them across ethnic and cultural boundaries. This is especially true of developmental models, which have been all but uniformly developed from empirical observation in Western settings, Akhtar said.

He cited as an instance the developmental model of separation and individuation espoused by Margaret Mahler, which he noted was derived largely from observation of white, upper-class children in Manhattan. Had she moved instead to rural Japan or India, "Margaret Mahler's theory and observations would be very different," he said.

"To take a theory developed from the observation of little white children from upper-middle-class Manhattan and generalize to all the world is a problem," he said. "If we try to transport lock, stock, and barrel developmental models evolved from the empirical observation of one set of situations to another set of situations, we are going to create problems. And from that we will create injurious models of psychopathology."

Concepts such as regression or the need for transitional objects, as well as corresponding formulations about what constitutes normal or abnormal behavior with regard to these and other developmental concepts, are apt to be very different from one culture to the next, Akhtar said.

Even the pace at which a child consolidates gender identity may be influenced by such culturally idiosyncratic factors as the internal structure of the language in which a child is raised—for instance, whether the language employs masculine and feminine verb forms.

"These developmental theories are not God-given facts," Akhtar said, "but hypotheses evolved from certain observations that need to be further tuned and modified without pathologizing alternate ways of responding."

Moreover, much of the language of psychoanalysis—drawing on what Akhtar called antiquated notions about the primacy of the body and anatomy in psychoanalytic thought—is received as lewd and offensive in Eastern societies, where the native language often lacks terms that are not considered obscene for private anatomy and sexual functions.

He cited as typical a Western academic interpretation of an ancient mythical tale about the god Shiva and his consort, Parvati, that relied on such concepts as Oedipal desire, erotic jealousy, and castration anxiety and that succeeded mainly in infuriating Eastern readers.

In its place Akhtar offered his own interpretation, drawing on more universal emotional motivations and longings understood within the specific cultural context of the story. "When we use psychoanalysis in antiquated, bodily oriented ways across cultures about sacred objects, with a language that is not transferable except in lewd terms, we lose our audience and we hurt people," Akhtar said. ■

Schizophrenia Treatment Should Focus On Recovery, Not Just Symptoms

Psychiatry has overemphasized pharmacotherapy of symptoms and underutilized proven psychosocial treatments, while paying little attention to the substantial medical complications confronting patients with schizophrenia, says one expert.

BY MARK MORAN

Functional outcome, not merely symptom relief, should be the clinical focus in the treatment of schizophrenia, said Stephen Marder, M.D., in an address titled "Recovery in Schizophrenia" at last month's Institute on Psychiatric Services in Atlanta.

Marder called for a new focus by psychiatrists on the physical health of patients with schizophrenia and incorporation of the broad range of proven psychosocial treatments. He also called for a new research agenda aimed at developing drugs to treat cognitive deficits—the feature of schizophrenia most strongly associated with functional outcome (see box on page 37).

The sum of those recommendations is a new orientation toward recovery, which Marder described as a process—not an endpoint—in which a patient can engage throughout the stages of illness even as he or she retains some symptoms.

This orientation marks a fairly major departure from standard psychiatric care, which Marder said has overemphasized pharmacotherapy of positive symptoms and underutilized proven psychosocial treatments, while all but ignoring the substantial medical complications confronting patients with schizophrenia.

"We need to have a paradigm of treatment that focuses on functional outcome as the most important outcome, with symptoms as things to be concerned about," Marder said. "We need to use both psychosocial and pharmacologic treatments. And I believe that psychiatrists and mental health care providers need to take more responsibility for the physical health of our patients, a serious problem that up until now has not been adequately addressed."

Marder is director of the section on psychosis of the UCLA Neuropsychiatric Institute and a professor of psychiatry at the David Geffen School of Medicine at UCLA.

For five decades, treatment of people with schizophrenia has largely relied on pharmacotherapy, and while those drugs have relieved much suffering, functional outcomes are not much improved from the point when antipsychotics were first introduced, Marder said.

"If a goal is [getting patients back to] work, only about 20 percent of patients with schizophrenia are currently working," Marder said. "And clinical practice, as it is engaged in clinics and hospitals, is largely focused on symptoms."

Marder emphasized that better treatment of cognitive deficits—not merely amelioration of symptoms—is the key to improving functional outcomes in people with schizophrenia.

"Symptoms can be handicaps on the way to recovery, but people can recover who have symptoms," he said."People can work who experience hallucinations and have suspicious thoughts, just as people can recover and prosper if they are missing a limb. It's a handicap, not the endpoint of treatment.

"Patients need to be at the center and be active partners in setting goals of treatment," he said. "But one of the obstacles is American psychiatry. Our focus on symptoms and away from the functional recovery that patients are asking for is why there is this controversy. Patients and families are

please see ***Schizophrenia*** *on page 37*

Déjà Vu Experiences Linked to Brain Region

Alzheimer's disease, schizophrenia, and déjà vu experiences have something in common—all involve the entorhinal cortex region of the brain. In fact, findings linking déjà vu to the entorhinal cortex may explain how schizophrenia delusions are formed.

BY JOAN AREHART-TREICHEL

In the murky interior of the brain's left and right temporal lobes can be found the entorhinal cortex. This structure is located not far from the hippocampus and is known to be vital for memory processing.

As the Alzheimer's disease process gets under way in the brain, the entorhinal cortex may be the first brain structure to deteriorate (*Psychiatric News*, September 1, 2000). Also, small left and right entorhinal cortices have been associated with the delusions of schizophrenia *(Psychiatric News*, October 1). And now, the entorhinal cortex has been linked with déjà vu phenomena—that is, the feeling of having already experienced the same place or event before.

The finding comes from Fabrice Bartolomei, M.D., Ph.D., an associate professor at the Service de Neurophysiologie Clinique in Marseille, France. Results appeared in the September *Neurology*.

Déjà vu experiences are a common feature of temporal lobe seizures and have often been reported after stimulating healthy subjects' medial temporal lobes. Such evidence suggests that the middle area of the temporal lobes gives rise to such experiences. But where in the middle region of the temporal lobes might déjà vu phenomena arise? Some research has suggested that it might be in the hippocampus and amygdala since electrical stimulation of these structures has, on occasion, provoked déjà vu experiences in subjects. However, the possibility that déjà vu experiences might arise from two other structures located near each other in the middle area of the temporal lobes—the entorhinal cortex and the perirhinal cortex—has not been explored. So Bartolomei and his colleagues decided to do so.

From 2000 to 2002, some 100 patients with drug-resistant epilepsy had a comprehensive evaluation at the clinic where Bartolomei and colleagues worked. This included the placement of electrodes in various areas of their temporal lobes to determine where their seizures were triggered and also to map areas in their temporal lobes involved in memory or language. The brain areas stimulated included not just the hippocampus and amygdala, but the entorhinal cortex and the perirhinal cortex.

Bartolomei and his team then focused on 24 of these patients or, more specifically, on the 280 electrode stimulations that these subjects had received to the hippocampus, amygdala, entorhinal cortex, and perirhinal cortex.

Déjà vu states, they found, were mostly associated with the entorhinal cortex. They occurred with 14 stimulations of the entorhinal cortex. In contrast, only two stimulations of the perirhinal cortex, two stimulations of the amygdala, and one stimulation of the hippocampus led to déjà vu.

Interest in Reminiscences

The investigators were also interested in locating the brain source of reminiscences. One subject, for instance, upon stimulation of the amygdala, thought that she smelled the scent of burnt wood. This olfactory hallucination reminded her of sitting around a campfire on a beach in Brittany when she was 14 years old.

However, it was only this one-time stimulation of the amygdala in one subject that produced such reminiscences, the researchers found. Stimulations of the hippocampus or entorhinal cortex provoked no such reminiscences. Yet, in contrast, five stimulations of the perirhinal cortex led to such reminiscences.

"Our study shows that an illusion of familiarity is often obtained after stimulation of the rinal cortices (entorhinal cortices or perirhinal cortices) and more rarely after hippocampal or amygdala stimulation," the scientists observed in their study report. How stimulation of the entorhinal cortex or perirhinal cortex actually produces such illusions is still a mystery, though, they stated.

Limitations Noted

"Since this study was conducted on treatment-refractory epileptic patients, the findings may not be generalizable to healthy subjects," Konasale Prasad, M.D., a research fellow at the University of Pittsburgh and one of the investigators who linked entorhinal cortex abnormalities with schizophrenia delusions, said in an interview. "Besides, we are not sure whether the raters who documented and interpreted the findings were blind. A control subject group or within-group control subjects with sham stimulations could have also been used to make the findings more robust."

Nonetheless, Prasad continued, "the findings are not only very interesting, but very strong and significant for the field of cognitive neuroscience. . . . This is the best direct evidence of entorhinal involvement in déjà vu states."

"The Bartolomei finding in a way explains our entorhinal cortex findings in schizophrenia," Matcheri Keshavan, M.D., a professor of psychiatry at the University of Pittsburgh and another of the scientists who linked entorhinal cortex abnormalities with schizophrenia delusions, told *Psychiatric News*.

"Perhaps an increased activation of the entorhinal cortex in some schizophrenia patients makes them attach a false sense of familiarity to otherwise neutral events, leading to delusion formation. Thus, in a classic example of a delusion, the patient sees a silver spoon on the table. Rather than dismissing it as an ordinary spoon of no relevance, his entorhinal cortex may attach a déjà vu–like feeling. The corrupted retrieval of the autobiographic memory system, perhaps involving the parahippocampal gyrus, weaves a delusion around that feeling—'This must mean that I have royal ancestry.' "

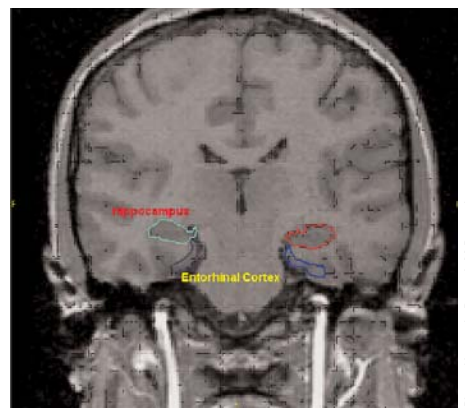


Photo: Konasale Prasad, M.D., et al.

This image of the human brain shows the location of the entorhinal cortex.

The study was funded by the Institut National de la Santé et la Recherche Scientifique and the University of the Mediterranean.

An abstract of the report, "Cortical Stimulation Study of the Role of Rhinal Cortex in Déjà Vu and Reminiscence of Memories," is posted online at <www.neurology.org/cgi/content/abstract/63/5/858>. ■

Treatment of Anxiety Increases, But Some Groups Left Out

Although more Americans are being treated for anxiety than in the past, there is still room for improvement—especially in the case of African Americans, Hispanics, and people with less education.

BY JOAN AREHART-TREICHEL

Anxiety disorders are among the most prevalent psychiatric conditions in the United States, yet people with anxiety disorders have tended to be underdiagnosed and undertreated *(Psychiatric News*, August 20).

Now there is some good news: The outpatient treatment of people with such conditions nearly doubled between 1987 and 1999—from 0.43 per 100 Americans to 0.83 per 100 Americans, a highly significant difference.

This finding has emerged from a study headed by Mark Olfson, M.D., a professor of clinical psychiatry at Columbia University and reported in the September *Journal of Clinical Psychiatry*.

Several factors may have contributed to this increase in treatment. For example, during the 1990s the drug industry intensely promoted the treatment of anxiety. The National Anxiety Disorders Screening Day program, which started in 1994, now operates in more than 1,200 sites in the United States. The Anxiety Disorders Association of America, which reorganized and expanded in 1990, provides consumer education material and a national network to facilitate local mental health referrals.

The study also contains some less upbeat results for the years 1987 to 1999, however—African Americans, Hispanics, and Americans with less than a high-school education had outpatient treatment rates for anxiety far below those of whites and Americans with more education. For example, the national rates per 100 persons treated for anxiety disorders in 1999 were 1.03 for whites, but only 0.37 for Hispanics and 0.24 for blacks.

These are among the other results of the outpatient treatment of anxiety:

• In 1987 anxiolytics such as benzodiazepines were the most commonly prescribed medications for the treatment of anxiety. By 1999, antidepressants were. This shift can probably be explained by various factors. For example, benzodiazepine use carries the risk of abuse and dependence, especially in patients with comorbid alcohol use disorders. In contrast, clinical trials have come to demonstrate the safety and efficacy of SSRI antidepressants for a range of anxiety disorders. In fact, since the completion of the 1999 survey, several of the newer antidepressants, including venlafaxine–extended release, sertraline, and paroxetine, have received Food and Drug Administration approval for the treatment of additional anxiety disorders.

• Nonetheless, nearly one-third of anxiety patients treated in 1999 were given benzodiazepines. One reason may be because some psychopharmacologists continue to endorse benzodiazepines as a primary or adjunctive treatment for several anxiety disorders.

• Patients treated for anxiety in 1999 were about half as likely to receive psychotherapy as they were in 1987. This decline occurred despite accumulating evidence of the efficacy of specific psychotherapies, especially cognitive-behavioral therapy, for anxiety conditions. In contrast, the treatment of anxiety with a combination of psychotherapy and psychotropic medication increased significantly between 1987 and 1999.

• In 1987, 76 percent of anxious patients were treated by a physician, 18 percent by a psychologist, 5 percent by a social worker, and the remaining by other providers. In 1999, in contrast, 78 percent were treated by a physician, 12 percent by a psychologist, 15 percent by a social worker, and the remaining by other providers.

Data for this study were drawn from the 1987 National Medical Expenditure Survey and the 1999 Medical Expenditure Panel Survey, two nationally representative surveys sponsored by the Agency for Healthcare Research and Quality to provide national estimates of the use, expenditures, and financing of health services. Some 35,000 individuals participated in the 1987 survey, some 24,000 in the 1999 one. Survey staff contacted medical providers to supplement and validate diagnostic and other clinical information given by participants.

The study had certain limitations. For example, whereas data about survey respondents' outpatient visits for the treatment of panic disorder, generalized anxiety disorder, phobias, obsessive-compulsive disorder, acute stress disorder, other anxiety states, and anxiety disorders, unspecified, were available for analysis, no information was accessible about respondents' visits for the treatment of posttraumatic

*please see **Anxiety** on page 28*

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Neuroticism, Anxiety Disorder Share More Than Symptoms

The same genes that cause neuroticism may cause generalized anxiety disorder. So highly neurotic people might be a good place to search for genes for generalized anxiety disorder.

BY JOAN AREHART-TREICHEL

High levels of the personality trait of neuroticism have been observed in patients with anxiety disorders, suggesting that the trait and such disorders might be related. In fact, the trait and generalized anxiety disorder could well be due to the same genes.

This hypothesis comes from a study headed by John Hettema, M.D., Ph.D., an assistant professor of psychiatry at Virginia Commonwealth University. A report of the results is published in the September *American Journal of Psychiatry*.

Generalized anxiety disorder is characterized by excessive, chronic worry regarding multiple areas of life and includes symptoms such as irritability, muscle tension, sleep disturbance, and difficulty concentrating.

To find out if generalized anxiety disorder and neuroticism are genetically related, Hettema and his colleagues conducted a large twin study.

They studied about 8,000 identical and fraternal twins, including twins of both genders. Subjects participated in either face-to-face or phone interviews to find out whether they had had generalized anxiety disorder at some point in their lives. The Structured Clinical Interview for *DSM-III-R* was used for this purpose. They were also assessed for neuroticism with the short form of the Eysenck Personality Questionnaire, which contains 12 items that overlap with some of the diagnostic criteria for generalized anxiety disorder such as irritability, nervousness, and excessive worrying.

The researchers then used the interview results to determine whether subjects who scored high on the personality trait of neuroticism had also experienced generalized anxiety disorder at some point in their lives. They found that was the case in many subjects, suggesting that neuroticism and generalized anxiety disorder might be genetically related.

They then looked to determine whether a coexistence of neuroticism and generalized anxiety disorder occurred more often in identical than in fraternal twins. They found that there was such a relationship, suggesting that the same genes that cause neuroticism could cause generalized anxiety disorder, since identical twins share 100 percent of their genes.

"Our results suggest that the genetic factors underlying neuroticism are nearly indistinguishable from those that influence liability to generalized anxiety disorder," Hettema and his colleagues concluded in their study report.

One of the implications of their findings, they added, is that people with high levels of neuroticism might be a useful starting point to hunt for genes for generalized anxiety disorder.

As for the study's implications for current psychiatric practice, "Although most psychiatrists do not routinely measure neuroticism," Hettema told *Psychiatric News*, "if there are indications of high neuroticism by whatever means, this would suggest that screening for generalized anxiety disorder would be a good practice. However, patients do not generally present with complaints of being neurotic, but rather because they have actually developed a psychiatric syndrome like generalized anxiety disorder, so the cat's already out of the bag."

The study was financed by the National Institute of Mental Health.

The study, "Genetic and Environmental Sources of Covariation Between Generalized Anxiety Disorder and Neuroticism," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/9/1581>. ■

Anxiety

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stress disorder or about respondents' visits for the treatment of anxiety due to specific medical illnesses. It was also not possible to determine whether respondents who received treatment for anxiety actually met diagnostic criteria for the selected anxiety disorder codes.

"It was encouraging to see the extent to which advances in treatment, especially advances in the use of antidepressants to treat anxiety disorders, have been disseminated into routine practice," Olfson said in an interview. Nonetheless, "little is currently done in a systematic manner to detect anxiety disorders in primary care. . . . Because many socioeconomically disadvantaged groups receive much of their mental health care within primary care settings, efforts should be made to improve the recognition of anxiety disorders in primary care together with referrals as appropriate to psychiatric care."

The study was funded by Wyeth Research.

The study, "National Trends in the Outpatient Treatment of Anxiety Disorders," is posted online at <www.psychiatrist.com/privatepdf/2004/v65n09/v65n0903.pdf>. ■

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letters to the editor

Psychotherapy Competency Debate

I read the article "Need to Prove Psychotherapy Competence Fuels Heated Debate" in the June 4 issue with great interest and found myself agreeing more strongly with the Yager/Rubin team.

The problems within our current training paradigms stem from the lack of agreement on what is the basic nature of current psychiatric treatment. Research has pointed to young psychiatrists having difficulty integrating the biologic and psychotherapeutic perspectives. Most training in what is called "psychodynamics" involves the rehashing of tired psychoanalytic concepts rather than conveying a modern understanding of the neurobiologic dynamism of mental life. Despite having the most recent annual meeting focused on the theme "Dissolving the Mind-Brain Barrier," we are not any closer in our consensual practice expectations to such an undertaking.

In my view, the teaching of psychotherapy should be subsumed under an overarching biologic framework such as "interpersonal neurobiology." This would put it squarely in the middle of the dominant thrust of the psychiatry of the 21st century. A rich body of literature from neuroscience offers insight into psychological change (changing one's mind-brain system). Specific technical modalities could be taught to mitigate dysfunctional states with the goal of mind-brain optimization. This would be both comprehensible to trainees and patients and would clearly be integrated within neuroscience.

A good introduction for residents might be Jerome Frank's *Persuasion and Healing: A Comparative Study of Psychotherapy*, Daniel Siegel's *The Developing Mind: Toward a Neurobiology of Interpersonal Experience*, and Lou Cozolino's *The Neurobiology of Psychotherapy*. The current competency standards in my view are a superficial attempt by the RRC to paper over a larger problem.

BARRY F. CHAITIN, M.D.
Newport Beach, Calif.

Clinical Trials Controversy

I very much appreciated the article in the July 16 issue titled "Clinical Trials Controversy Spotlights Flawed System." I concur that the problem also exists in medical specialties other than psychiatry. The first three paragraphs of the article do indeed echo the feelings of clinicians like me ("in the trenches," as the article states) about the lack of reliability of data from pharmaceutical companies, causing us to "wonder what we really know, or perhaps don't know . . . [and] seriously challenges physicians' comfort level with prescription drugs . . . ."

These three carefully worded paragraphs do not point blame at individuals. In fact, the article makes a show of even-handedness in its reference to the article in the April *Lancet* by Jon Jureidini, M.D., of Australia, who blew the whistle on this latest example of egregious behavior.

In contrast to the Aussie proclivity for bluntness, the article states: "At best, Jureidini's conclusions were direct and to the point, but by some people's estimation the conclusions seemed inflammatory, with abundant references to the individuals who led the research or wrote the articles, rather than to the research methods, data analysis, or conclusions."

Come on. When individuals signed their names to misleading material, why shouldn't they be named in a rebuttal? It is a cheap shot to label this kind of directness "inflammatory." I say three cheers for the Aussies, who, after all, have their heads on right side up.

MALCOLM A. SOWERS, M.D.
Castro Valley, Calif.

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.

This article points out the dangers of psychiatrists' being wedded to pills instead of skills. Although better clinical data will tell us more about the benefit and safety of antidepressants, they will do nothing to dispel the idea that child psychiatrists now favor medication over therapy. This is the reversal of a time-honored perspective about work with children, which has existed since the dawn of civilization.

Cognitive-behavioral therapy (CBT) for childhood depression has shown efficacy in clinical trials; is easy to learn and teach; exists in manual form, which can be adapted to most clinical situations; and is useful with most children and adolescents of average intelligence who can grasp mental reasoning concepts.

Why not have child psychiatrists use CBT with depressed patients in place of or in addition to medications? That way one might increase treatment success rates. At least it would empower children and parents to do something while waiting to see what happens to their children. And please, let's not cede this treatment to other therapists without trying it first ourselves.

One way to encourage this "skills and pills" practice is to get it incorporated in the Texas Medication Algorithm Project for depressed children. It could require CBT whenever possible in place of, and in addition to, any antidepressant trial. What harm would it do? I cannot think of any. As far as I am aware, no suicide has been reported as a side effect of CBT. What good would it do? A lot—especially to restore the balance in treatment between active therapy and passive pill taking.

KIM MASTERS, M.D.
St. Simons Island, Ga.

Video

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marginalized groups" and "helps to place psychiatry in a favorable light as a medical specialty, demystify the profession, and reduce the stigma of mental illness."

The following psychiatrists are featured in the film, which was produced and directed by Ginny Durrin of Durrin Productions Inc. in Washington, D.C.

Psychiatrists Save Lives

During a typical week, Curtis Adams, M.D., has the capacity to reach as many as 60,000 people—though admittedly, the majority of these aren't his patients.

In addition to his roles as an assistant professor in the University of Maryland's Division of Community Psychiatry, senior psychiatrist at the Carruthers Clinic in Baltimore, and member of the Programs for Assertive Community Treatment (PACT) team at the University of Maryland, he can be heard on the radio discussing mental health issues and how they impact African Americans.

Each Wednesday afternoon, Adams takes his seat at the microphone as a guest on the radio show "Mind, Money, and Medicine" on WOL 1450-AM in the Baltimore-Washington, D.C., area. During the weekly broadcast, Adams has a chance to teach the public about what psychiatrists do when they treat patients.

"I know there is a lot of stigma surrounding mental illness," Adams explains in the video. "But this is no different from having heart disease or hypertension—we're talking about the presence or absence of an illness, and if it's an illness, we can treat it."

As a member of the Maryland PACT team, Adams is filmed climbing the stairs of a rundown apartment building to give one of his patients a monthly injection of antipsychotic medication.

Of his surroundings, Adams says, "These folks are at the mercy of competing challenges—people selling drugs in their neighborhoods and an overabundance of liquor stores. It's very difficult."

In his role as senior psychiatrist at Carruthers Clinic, Adams can be seen removing sutures, giving injections, and taking blood from patients. "We do primary care, essentially," he said of his work there.

"People don't think we are in the business of saving lives in psychiatry, and we absolutely are," he added. "Many psychiatric illnesses carry a risk of death by suicide—so if you are able to intervene and prevent suicide, that is lifesaving."

Adams told *Psychiatric News* he became a psychiatrist because "I love people's stories. . . .I love to know where people come from and maybe have an influence on where they are headed."

Adams has two children and thinks of psychiatry as a "family-oriented specialty. . . . We allow one another to be good parents," he said.

Psychiatry Runs in Family

Having a positive impact on her patients is also one of the most satisfying parts of the job for Mercedes Martinez, M.D., a child and adolescent psychiatrist in Chicago.

"I've always said if I can help one child turn his or her life around, I've done something productive," she said in an interview with *Psychiatric News*.

Martinez said she has always been fascinated by child development and has three children of her own who keep her grounded.

In addition to her role as a clinical assistant professor of psychiatry at the Rosalind Franklin University of Medicine and Science (formerly known as Chicago Medical School) and senior fellow with the National Center for Health Behavioral Change at Morgan State University in Baltimore, Martinez works at several Chicago-area health clinics, including Circle Family Care Health Clinic and Salud Family Health Care Clinic, where she trains family practice residents.

She also works at Allendale, a residential facility in Lake Villa, Ill., for children and adolescents with serious emotional disturbances.

Martinez said there is an urgent need for child and adolescent psychiatrists in inner-city and rural areas, especially those who are bilingual and understand the issues faced by minority youth with mental illnesses. "Universities need to be held accountable for recruiting, retaining, and graduating Hispanic doctors," she said, "especially in the area of child and adolescent psychiatry."

Psychiatry is in Martinez's blood, one might say.

Her father, Emilio Espindola, M.D., completed his psychiatry training in Mexico before coming to the United States at a time when accreditation from foreign medical schools was not accepted by U.S. programs. "He loved psychiatry so much that he completed a second residency in the U.S.," Martinez explained.

Part of her childhood was spent on the grounds of a state hospital in Elgin, Ill., one of the places where Espindola practiced.

"Seeing how much his patients loved him and how much he gave of himself to the community" inspired her to pursue a medical career in psychiatry, she said.

Practicing Without Reservation

Two father figures from different worlds propelled Mary Roussel, M.D., down the path to a psychiatry career. The first was her grandfather, a Navajo medicine man, and the second was famed psychiatrist Karl Menninger, M.D., who founded the Menninger Clinic in Topeka, Kan., and died in 1990.

Menninger was fascinated with the Navajo healing process, Roussel said, and began a professional relationship with Roussel's father, who was director of an Indian education center at Arizona State University.

Menninger soon became a family friend, and Roussel said she can remember him conversing with her grandfather with the help of an interpreter about the art of Navajo healing.

According to Roussel, Navajo medicine involves ensuring that "mind and body are in harmony, and people are in harmony with the world around them."

So it was not a leap for Roussel, as a Navajo woman, to enter a medical specialty in which treatment takes into account mind, body, and spirituality, she said. She is also married to a psychiatrist.

Roussel treats American Indian patients from different tribes at the Santa Fe Indian Hospital. She also works at clinics associated with the hospital, such as the Santa Clara Clinic, which is adjacent to the Santa Clara Pueblo reservation, 30 miles north of Santa Fe.

In addition, she is chair of the steering committee on Native American Psychiatry at the University of New Mexico.

Roussel encouraged American Indians to get involved in medicine, and in particular psychiatry.

She noted that although nonnative physicians come to practice on Indian reservations, "they are not familiar with Native-American people and have never lived on a reservation. . . .These things are hard for them to get used to," Roussel said.

Many leave the reservations after a year or so, and as a result Native-American patients lack much-needed continuity of care, she added.

Stimulating the Intellect

Lowell Tong, M.D., a psychiatrist in the San Francisco area, said the "fascinating and intellectually challenging" experiences with patients he encountered as a medical student at the University of Virginia made his decision to enter psychiatry an easy one.

For instance, during one of his psychiatry rotations, he met a patient who had a deeply held delusion about a certain facial feature and spent hours scrutinizing himself in the mirror.

Tong recalled the patient as a "polite and well-put-together kind of person who was otherwise coherent." Tong recalled, "I thought in my own naive way—'this guy isn't really that sick. Let me just sit down with him and correct his misunderstanding.' "

Soon Tong realized the depth and intractability of the patient's delusion, which was related to other psychotic symptoms.

"Everything else I learned as a medical student made too much sense to me," Tong told *Psychiatric News*. "I knew everything about bacteria, and I understood blood cells," he recalled. "But no one could explain why he had this delusion, and I was challenged intellectually in a way I'd never been before."

Tong enjoys his roles at the University of California, San Francisco, as a clinical professor of psychiatry, director of medical student education in psychiatry, and principal career advisor for medical students who are interested in psychiatry. "My goal is to give all students a solid understanding of psychiatry," he said.

He also enjoys life outside of work with his partner, Alasdair Neale, a symphony conductor. "We're both very busy but cherish the time we have together," Tong said.

A free copy of "Real Psychiatry: Doctors in Action" is available by calling APA toll free at (888) 35-PSYCH or sending an e-mail request to apa@psych.org. Each additional copy of the video costs $10 for VHS and $15 for DVD. APA members can also view the video on APA's Web site at <www.psych.org>. ■

NAMI

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take McGraw's statements as a sign that mental health care may not be an urgent consideration for their troubled child as long as they adopt better parenting skills.

In a written response to NAMI, McGraw's executive producer, Carla Pennington Stewart, and the show's psychological consultant, G. Frank Lawlis, Ph.D., suggested that NAMI leaders' response was "the result of a lack of information," and that McGraw did not blame the parents for their child's illness. "We never discouraged alternative treatments" for Eric, they said. "The parents ruled out potential biological causation through comprehensive evaluations with appropriate doctors. No treatment was available due to the absence of a diagnosable biological/organically based condition. Having exhausted all other avenues of intervention, they sought our help." They added that the doctors who had assessed Eric "ruled out" the presence of a mental illness, "including bipolar and related disorders."

NAMI's response to the Dr. Phil show can be accessed online at <www.nami.org/template.cfm?section=press_room> by clicking on "NAMI Blasts CBS. . . ." Information about the "Dr. Phil" program, including parenting advice, is posted at <www.drphil.com>. ■

Obesity

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port, the Child and Adolescent Trial for Cardiovascular Health, efforts were made to improve diet and increase physical exercise among children at 48 elementary schools and then to compare them with children at 48 elementary schools where such efforts were not made. Although the youngsters in the intervention schools ate less fat and exercised more than youngsters in the control schools, at the end of the study they did not weigh less than the latter.

In the Planet Health Trial, in contrast, 10 schools were randomized to classroom-intervention sessions or control sessions for a two-year period. Behaviors targeted for change in the intervention sessions included increased fruit and vegetable intake, increased physical activity, and decreased television viewing time. At the end of the study, obesity prevalence among girls in the five intervention schools was significantly less than among girls in the five control schools. (There was no significant difference in obesity prevalence between boys in the two schools.)

• Efforts to prevent childhood obesity are getting under way in the United States. They range from state legislation regarding school physical education requirements and nutrition standards for beverages and foods sold in schools to new school-board policies and community initiatives to expand bike paths and improve recreational facilities.

The Institute of Medicine report also contains some compelling recommendations, notably:

• The president should ask the secretary of the Department of Health and Human Services to convene a high-level task force to establish goals for countering childhood obesity.

•Medical organizations should make childhood obesity prevention a high-priority goal. (For example, the report noted that the American Academy of Pediatrics has created a task force to deal with child obesity and is involved in a public-private partnership to counter excess weight, poor nutrition, and lack of physical activity among America's youth.)

• There are currently no legal restrictions on the marketing of unhealthy foods to children. However, good evidence suggests that such restrictions could slash childhood obesity.

• More research on the prevention of childhood obesity needs to be undertaken, especially research examining factors that might improve youngsters' dietary and physical behaviors.

A copy of the report, "Preventing Childhood Obesity: Health in the Balance," can be purchased from the Institute of Medicine–National Academy of Sciences by calling (202) 334-3180. ■

BMS ABILIFY
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Dosage

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mean serum haloperidol concentration and higher rating for extrapyramidal symptoms than did white patients.

When a larger group of Taiwanese patients and Caucasian patients were administered fixed doses of clozapine, researchers found that serum levels of the drug were 30 percent to 50 percent higher in the Asian patients, Chou said.

Metabolism varies from drug to drug, he added. "Asians have reduced metabolism of haloperidol, risperidone, and clozapine, but not of olanzapine," Chou said.

In a small, unpublished study of olanzapine, Chou cited, Asians and Caucasians metabolize the drug at similar rates.

Chou concluded that the literature on psychopharmacology for Asians is "weak," and although there is evidence that Asian patients do metabolize some medications more slowly than Caucasian patients, he advised psychiatrists to "dose based on the response of the individual patient."

Medications are only part of the treatment for Asians with mental illness, of course. Psychotherapy may be an important part of the recovery process for many Asian patients, and psychiatrists and mental health professionals should be mindful of certain elements of Asian culture when conducting psychotherapy, according to Ramaswamy Viswanathan, M.D., an associate professor of psychiatry at the State University of New York, Downstate Medical Center.

Viswanathan emphasized that clinicians should also be attentive to individual and subcultural differences when working with Asian patients.

While American society tends to stress the value of freedom and individuality, Asian society "stresses conformity and obedience to authority," he said.

The value of privacy is critical in American society, but in Asian communities, "your family knows everything about you, and even your neighbors know a lot about you," he said.

In Western societies, it may be acceptable to express negative emotions, but this is not so in Asian culture. Talking about negative emotions "is a disgrace to the patient and family" he noted. "Somatization of illnesses such as depression is much more acceptable."

Viswanathan also noted that "an Asian patient's first mental health visit is likely to be initiated by a family member, and the majority of Asian patients are accompanied by one or more family members."

When this happens in his practice, Viswanathan said he gently suggests to the family members that he needs to be alone with the patient "to give the patient a chance to express things they don't want to express in front of the family," he said.

He also noted that Asian patients are receptive to problem-focused cognitive-behavioral interventions "because the principles are similar to Eastern philosophy, and relaxation is similar to meditation."

He added that "interpersonal therapy, which emphasizes roles and social relations, may also resonate with Asian traditions." ■

Asian Patients

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ers that keep many Asian Americans away from the mental health system may improve utilization of mental health services in this population, Chung said. "An ethnic match between clinicians and patients can increase treatment utilization and retention."

Individually, clinicians can more successfully engage Asian-American patients by helping them to achieve goals valued in Asian culture.

"Asian patients value employment, a concrete means of demonstrating their value to society and to their families," Chung said. "One way to engage Asian patients is to ask, 'What if I were to tell you that by getting treatment, I could help you to be more satisfied with your job and family?' "

Chung recalled antidepressant advertisements in which consumers wore wide smiles after receiving treatment. "That does not work for this community," he said. " 'Don't worry about the smile—I want a job, a future for myself, and a future for my family. Do that for me, and maybe I'll listen to you.' "

Chung encouraged clinicians to "organize ways of engaging patients and improving coordination of care," for Asian patients, which includes streamlining treatment plans that are unnecessarily complex.

He also advised them to adopt evidence-based treatments. "We need to take what works, adapt it to our practices, and then put it to work in our communities," he said.

More information about the New York Coalition for Asian American Mental Health is posted online at <www.asian-mentalhealth.org/>. ■

HIPAA

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As of April 2003 physicians were required by the law to notify patients of their privacy rights under the law and how their information will be used, to document procedures for protecting and securing health information and train employees in the procedures, to designate a privacy officer, and to secure patient records.

But Harding stressed that the privacy and security requirements in HIPAA are preempted by state laws that may be much stricter. "HIPAA is a floor," he said. "You may be doing what HIPAA says, but there may be state laws that say you have to do better. HIPAA isn't the ultimate, but the base on which all of us are encouraged to practice."

A number of questions about the law await resolution, most likely in the courts. Among them: Who is responsible for breaches of privacy and security of information by business associates who have access to patient information? How much information are patients' relatives entitled to? How much and what kind of information can be divulged to public health agencies or to schools seeking immunization records?

In the case of the latter, Harding said it has happened that children have had to receive all new vaccinations after they move with a family to new location because a physician in the former location refuses to release vaccination records on the grounds that a school is not a covered entity under the law.

He described a scenario in which a family moved from Chicago to Atlanta with three school-age children. From the new location, the parents called the physician in Chicago and requested that he send vaccination records for the children to the new school in Atlanta. The physician refused to do so without written authorization, signed by the parents; the parents asked whether they could fax the authorization, but the physician insisted that they return to Chicago to provide a "live" signature.

"Some lawyer convinced that doctor that if he gives away that information, he will go to jail and get fined a quarter-million dollars," Harding said. "Now many doctors refuse to divulge any health information without authorization."

In the meantime, Harding advised that the surest path to securing information was to formalize policies and distribute those policies to employees. Files should be locked and access should be limited. Workstation guidelines should be developed, as should a system for tracking who has access to patient information. And policies should be developed around terminated, possibly disgruntled, employees who may have had access to patient information, Harding said.

Updated information on HIPAA is posted at the HHS Web site at <www.hhs.gov/ocr/hipaa/>. ■

Schizophrenia

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asking for a recovery model, and we need to respond."

Marder outlined the psychosocial treatments that have a literature of efficacy behind them when combined with antipsychotic medication. These include illness education, family interventions, supported employment, assertive community treatment, skills training, and cognitive-behavioral therapy.

He emphasized that evolving research on psychosocial therapies has shown that they act on different aspects of the patient's illness than do medications. For instance, he described studies showing that skills training had no impact on relapse, but had a profound effect on social outcome and patient quality of life.

He also stressed that the effects of psychosocial treatment are generally not seen in the short term. "Psychiatrists underestimate the effectiveness of these treatments because patients don't receive them long enough," Marder said.

He especially highlighted the importance of supported employment. "No treatment I have seen is as effective as a part-time job," Marder said. "Nothing contributes as much to self-esteem and community integration than being able to interact with co-workers on a regular basis, and there is nothing more reinforcing to a patient than being given a positive review by a supervisor and being paid for one's work."

Marder said a most urgent change necessary in the treatment of schizophrenia is a new attention on the part of mental health professionals to the medical complications typically seen in the disease.

Patients with schizophrenia have a high smoking rate and are at higher risk for obesity, diabetes, and hypertension. He said the average lifespan for a patient with schizophrenia is 15 years less than the general population. "The increased risk for suicide has little to do with it," he said. "Our patients are dying of heart disease."

Marder described a conference on the subject in late 2002 at Mount Sinai University School of Medicine in New York that brought together a host of experts on schizophrenia, diabetes, heart disease, and preventative health, among other topics.

Consensus recommendations developed at the conference called for regular monitoring of body mass index, plasma glucose level, lipid profiles, and signs of prolactin elevation or sexual dysfunction—all of which should guide the selection of antipsychotic agents *(Psychiatric News*, March 5, September 17).

Specific recommendations were made for cardiac monitoring of patients who receive medications associated with QT interval prolongation and for monitoring for signs of myocarditis in patients treated with clozapine. Patients who receive both first- and second-generation antipsychotic medications should be examined for extrapyramidal symptoms and tardive dyskinesia. Patients with schizophrenia should also receive regular visual examinations, according to the recommendations. These recommendations appeared in "Physical Health Monitoring of Patients With Schizophrenia" in the August *American Journal of Psychiatry*.

"Implementing these recommendations in a psychiatric setting isn't going to be easy, but it is self-evident that it should be happening," Marder said. "The treating psychiatrist may not be able to manage many of these medical problems, but they need to be certain that someone does." ■

Developing Drugs to Target Cognitive Deficits

Efforts are under way to attract drug company interest in developing medications to improve the cognitive functioning of patients with schizophrenia, the feature of the disease most strongly associated with functional outcome.

Stephen Marder, M.D., described several efforts in this area, including a program at the National Institute of Mental Health known as the Measurement and Treatment Research to Improve Cognition in Schizophrenia (MATRICS). These are the specific goals of MATRICS:

- To catalyze regulatory acceptance of cognition in schizophrenia as a target for drug registration.
- To promote development of novel compounds to enhance cognition in schizophrenia.
- To leverage the drug industry's economic research power to focus on important but neglected clinical targets.
- To identify lead compounds and, if deemed feasible, support human proof of concept trials for cognition in schizophrenia.

Marder also cited another NIMH-funded program called Treatment Units for Research on Neurocognition in Schizophrenia (TURNS). The TURNS program will provide an infrastructure for clinical studies of pharmacological agents for enhancing neurocognition in patients with schizophrenia.

Marder is the principal investigator in both of those programs. Information about them is posted online at <www.matrics.ucla.edu> and <www.turns.ucla.edu>.

HS--JOB BANK
PBW

Cost Factors

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ceived treatment for mental health problems. About 1.8 million adults were hospitalized for mental health problems, according to the survey.

When researchers analyzed demographic information for those who received treatment, they found the rates of treatments were highest for those reporting that they belonged to two or more ethnic groups (17.5 percent) or who were white (15.3 percent).

Ethnic Differences Found

African Americans had lower rates of mental health treatment (8.5 percent) than did whites; the same was true for Latinos (8 percent). Asian Americans had the lowest treatment rates (4.9 percent).

Among the 19.6 million adults with serious mental illness in the United States, 9.3 million, or 47.3 percent, received treatment.

As for the 5.9 million people with serious mental illness who perceived an unmet treatment need, cost or insurance issues were cited most often for not receiving professional help (see chart on page 6).

The survey also found that an estimated 21.6 million Americans had a substance dependence or abuse problem in 2003, representing about 9 percent of people aged 12 or older.

The majority were dependent on or abused alcohol (14.8 million), while 3.1 million were dependent on or abused both alcohol and drugs, and 3.8 million were dependent on or abused drugs alone.

Only about 3.3 million people aged 12 or older received some kind of treatment for a problem related to alcohol and/or drug use the previous year, the survey found, yet an estimated 20.3 million people needed such treatment but did not receive it.

Stigma, Costs Deter Many

Of the 20.3 million Americans who needed but did not receive treatment in 2003, only about 1 million said they felt they needed treatment for their alcohol and/or drug problem at the time of the survey.

Need was determined by virtue of meeting *DSM* criteria for substance abuse or dependence.

Of this latter group, 273,000 reported they had made an effort to get treatment but did not get it for various reasons.

The majority of those who said they made an effort to get treatment felt they were not ready to stop using the substance (41.2 percent), cited barriers related to high costs of treatment or problems with insurance (33.2 percent), said they were afraid of being stigmatized (19.6 percent), or reported that they believed that they could handle the problem without treatment (17.2 percent).

More information about the 2003 National Survey on Drug Use and Health is posted online at <www.oas.samhsa.gov/nhsda.htm#NHSDAinfo>. ■

Borus Honored

Professional News

Jonathan F. Borus, M.D, a professor of psychiatry at Harvard Medical School and chair of the Brigham and Women's/Faulkner Hospitals department of psychiatry, was presented with the Lifetime Achievement Award of the Association for Academic Psychiatry, the national organization of psychiatric educators, at the association's annual meeting in Albuquerque last month. ■

association news

Board

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tions and, TSPP leaders hope, will raise the visibility of organized psychiatry in Texas, Sawyer said.

Denney told the Trustees that TSPP members "don't want to be disengaged from APA" and warned that any such disaffiliation will end up damaging APA, as well as the district branch. APA might want to consider becoming a member of the Texas federation, he suggested.

Of the 13 members the academy had as of the October Board meeting, he added, seven had resigned from APA and TSPP or had their memberships terminated because of failure to pay dues. The latter category included the academy's president, Sanford Kiser, M.D., Sawyer told the Board.

Trustees Explain Concerns

The presentations by the three TSPP leaders left many Board of Trustees members concerned about the implications for APA and the future of the Texas district branch. Area 5 Trustee Jack Bonner, M.D., whose Area includes Texas, said that despite protestations to the contrary from Sawyer, the new structure still seems designed "to circumvent the intent of the dual-membership requirement."

Immediate past president Marcia Goin, M.D., raised the issue of use of funds that APA provided TSPP for state-level lobbying on scope-of-practice issues, since it was explained that the federation, not the TSPP, would become the chief advocacy group for psychiatrists in Texas. The TSPP leaders did not respond to her concern during the session.

Paul Appelbaum, M.D., who preceded Goin as APA president, suggested that the "surprise" that TSPP leaders had expressed in response to APA's strong objection to this and the affiliate proposal was an indication that they did not understand APA's concerns. He explained the objections by emphasizing that despite TSPP's claims, the academy is in essence competing for psychiatrists with the district branch and thus "negating the dual-membership requirement" that the Board believes is "essential for the future of organized psychiatry."

If other district branches follow TSPP's lead, he said, it could siphon off APA members, leaving "both the DBs and the national APA with fewer resources and fewer members" and serve as the "opening wedge in what could be the devastation of APA."

After the presentations and questions, the Board went into executive session to discuss the situation further. Following that closed-door session, the Board issued a statement saying it "anticipates that a further response to the TSPP action will be forthcoming shortly."

At press time, the Assembly planned to discuss the developments in Texas at its November meeting. A report of that meeting will appear in the next issue.

Other Actions

The Board also had several other issues on its agenda, voting to

- **implement a one-year formula that APA would use to provide grants to the district branches (DBs).** Every DB except those in California, New York, and Missouri (the only states with multiple DBs) will receive $2,500 in 2004. In California and New York, $2,500 will be given to each state association. In Missouri, which has no state association, the three DBs will receive equal shares of the $2,500 grant. The remainder of the $280,000 budgeted for DB grants will be distributed according to the number of voting members in each DB.

- **support requests for funds to support advocacy and educational activities by DBs** in Florida, Iowa, Kentucky, and New Mexico.

- **support the idea of amending APA's Bylaws to make the APA medical director the Association's chief executive officer.** Currently, the chief executive officer is the president, who changes every year. The Bylaws Committee will begin the process of preparing to change this section of the Bylaws; such amendments require a vote of the membership or Board of Trustees with ratification by the Assembly.

- **require that annual budget surpluses not earmarked for current or future Association activities be applied to APA's reserve replenishment fund.** This will be in effect until that fund is equal to 40 percent of APA's unrestricted operating expenses.

- **have appropriate APA components develop a position statement supporting the right of same-sex couples to marry.** The Board wants to have a draft statement to review at its December meeting.

- **write off APA's remaining valuation of Medem,** which is $856,000. APA remains a Medem stockholder, but the Board took this action since the shares have almost no value at this time and thus should not continue to be listed as an asset on APA's balance sheet.

- **approve a resolution opposing the imposition by the federal government of additional controls on the availability of the opioid treatment buprenorphine,** emphasizing that such restrictions "would be unwarranted and detrimental to the public health." The resolution, developed by the APA Council on Addiction Psychiatry, notes that "various forces" are trying to convince government officials to reclassify buprenorphine as a Schedule 2 narcotic, which would bar its use in office-based settings. A 2000 law approved the drug's use as an office-based treatment for opiate addiction if physicians were certified to use it in outpatient settings.

- **approve a Presidential New Initiatives Fund,** which will make $25,000 available each year for the president to use for special projects. The money will be available for three years, beginning in the president-elect year. ■

Summary of Texas Organizations

Leaders of the Texas Society of Psychiatric Physicians (TSPP) and other Texas psychiatrists have participated in the formation of a new structure for organized psychiatry in the state that has drawn a strong, negative reaction from the APA leadership (see story on page 9). The three key components in this structure are the TSPP, Texas Academy of Psychiatry, and Federation of Texas Psychiatry.

- TSPP is the state's APA district branch (DB), and APA policy requires, as is the case for all DBs, that a psychiatrist join both the district branch and the national APA. TSPP members continue to receive the benefits of both DB and APA membership.

- The Texas Academy of Psychiatry, formed during the summer, is an organization for individual psychiatrists whose dues are the same as those for TSPP, but which does not require membership in APA. The academy's members will receive benefits that are similar to those TSPP members get from the DB. Academy members will not, however, receive APA benefits such as subscriptions to the *American Journal of Psychiatry* and *Psychiatric News* and reduced fees for CME activities and registration at APA annual meetings.

- The Federation of Texas Psychiatry is a nonprofit umbrella group whose members are organizations in the psychiatric field, though it may open membership to interested nonpsychiatric organizations such as those involved in advocacy. The federation's staff is the former staff of the TSPP, who resigned their posts and now provide administrative support to the TSPP under a contract between the federation and TSPP. TSPP is sharing office space with the federation and the academy. The exact services that the federation will provide to TSPP had not been finalized at press time.

"The federation will provide the means for TSPP and the academy to share programs and work together," wrote Conway McDanald, M.D., chair of the Federation Delegate Assembly, in the October/November *Texas Psychiatrist.* "Thus, by uniting the two major psychiatric organzations in Texas, the voice and influence of psychiatry will be strengthened. . . . How you choose to participate is your choice. TSPP and the academy are both outstanding organizations working for Texas psychiatry."

government news

Medicaid

continued from page 16

17.7 percent to 24.7 percent during the years analyzed.

Medicaid is also an important payer for child psychiatrists and for those who work in clinics.

A report issued on October 13, after the KCMU briefing, by the National Association of State Budget Officers found that Medicaid costs increased more than any other area of state spending in Fiscal 2003 and are expected to consume a greater proportion of states' total spending than elementary and secondary education in Fiscal 2004.

The factors that account for the growth in expenditures suggest that this scenario is likely.

Smith said that Medicaid officials reported that spending growth was driven by "three key things:" enrollment growth, increasing costs of prescription drugs, and increasing costs of medical services in general. Costs related to each of those factors are increasing.

A new factor will be the impact on states' spending of the implementation of the new prescription drug benefit under Medicare. Under the new law, states will be required to pay the federal government for the drug costs associated with over six million low-income seniors who quality for both Medicaid and Medicare (dual eligibles). Their prescription drug coverage will be shifted from Medicaid to Medicare in 2006.

According to the KCMU-commissioned survey, more than three-quarters of states were concerned about the costs of this payment and the administrative burdens and other net costs they may occur due to the implementation of this benefit.

Health care advocates have challenged the most controversial methods to contain Medicaid costs.

At the end of September, Tennessee Gov. Phil Bredesen (D) sent the Centers for Medicare and Medicaid Services (CMS) his plan, which requires federal approval, to restrain costs by limiting doctor visits and other medical treatment and increasing copayments and premiums.

The plan also includes a definition of "medical necessity" that would require doctors to use "the least costly alternative" for a treatment that is "adequate" to the medical problem *(Psychiatric News,* August 20).

Jacobs said, "That definition is particularly troubling because it could undermine existing statutory protections for Medicaid patients. The weakening of those protections coupled with states' budgetary problems could result in real harm to them."

Since the plan was first proposed, Bredesen has exempted children from some of the proposed restrictions, but not from the definition of medical necessity.

Forty-six national advocacy organizations, including the National Mental Health Association, the National Council for Community Behavioral Healthcare, and the American College of Obstetricians and Gynecologists, sent a letter to Bredesen in September pointing out dangers of his proposal, and they plan a letter to CMS.

In late September, the Mississippi Center for Justice, AARP Foundation Litigation, National Senior Citizens Law Center, and National Health Law Program filed a lawsuit challenging the state's elimination of Medicaid benefits for about 50,000 beneficiaries. In mid-October, a Mississippi judge granted a temporary injunction prohibiting the change until January 31, 2005.

"The Continuing Medicaid Budget Challenge" is posted at <www.kff.org/medicaid/kcmu100404nr.cfm>. ■

Association News

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