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Articles with "see" references appear as follows:
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Assembly members Jeffrey Geller, M.D. (left), Isabel Bergman, M.D., and Guillaume Barbes-Morin, M.D., join Team APA in a walkathon sponsored by the National Alliance for the Mentally Ill last month in Washington, D.C. The walk raised money for psychiatric research and education. See page 2.

Government News

FDA Vows to Improve Drug-Safety Assessments

Serious concerns over how the FDA handled the highly publicized safety concerns surrounding antidepressants and Vioxx have prompted the agency to change course with respect to protecting public safety.

BY JIM ROSACK

Amid ongoing concerns that it has failed to protect the public health, the U.S. Food and Drug Administration (FDA) announced last month that it would take five steps toward strengthening the agency's drug safety programs. The move comes in the wake of ongoing Congressional inquiries into how the agency responded to and managed early concerns about the safety of antidepressants and the anti-inflammatory COX-2 inhibitor, rofecoxib (Vioxx).

Lester M. Crawford, D.V.M., Ph.D., acting FDA commissioner, said "modern drugs provide unmistakable and significant health benefits, but experience has shown that the full magnitude of some potential risks have not always emerged during the mandatory clinical trials conducted before approval."

The recent examples of pediatric use of antidepressants and risk of heart attack or stroke associated with Vioxx, he noted in a prepared statement posted on the FDA's Web site, are the latest examples of "serious adverse events that are identified after approval, either in postmarketing clinical trials or through spontaneous reporting of adverse events."

The FDA, Crawford continued, has a drug safety program "designed to assess adverse events identified after approval." But, he cautioned, "detecting, assessing, managing, and communicating the risks and benefits of prescription and over-the-counter drugs is a highly complex and demanding task. The FDA is determined to meet this challenge."

Crawford outlined a five-step plan to be undertaken by the FDA's Center for Drug Evaluation and Research (CDER), beginning with an FDA-sponsored review by experts from the National Academy of Sciences' Institute of Medicine (IOM). An IOM committee will study the effectiveness of the U.S. drug safety system, with an emphasis on the postmarket phase, and will assess what additional steps could be taken to learn more about the side effects of drugs as used by consumers. The committee will also recommend measures aimed at enhancing the confidence of Americans in the safety and effectiveness of available drugs. The timeframe for these activities has not yet been determined.

Second, CDER will formalize a "program to provide an improved process ensuring that the opinions of scientific reviewers are incorporated into its decision-making process." This step comes in response to stern criticism from Congressional inquiries that uncovered

please see ***FDA*** *on page 43*

Government N

California Voters Say Rich Should Help Fund MH Care

California voters choose an innovative route to increase mental health care funding.

BY KATE MULLIGAN

California voters agreed to tax the rich to support public mental health services.

More than half of them (53.3 percent) voted last month in favor of Proposition 63, which will impose a tax surcharge of 1 percent on the taxable personal income above $1 million to pay for services offered through the state's existing mental health system. The initiative will generate an estimated $700 million a year.

"We're ecstatic," said Randall Hager, legislative director for the California Psychiatric Association (CPA). "It's hard to come up with words to describe the importance of what happened. This could be the beginning of a whole new era for the public mental health system. We hope to make good on broken promises to people with mental illness."

The effort was led by a coalition, the Campaign for Mental Health (CMH). CPA was one of the early supporters. "It's been a high priority for us," said Hager. "We helped develop the concept and have been rallying our members."

Richard A. Shadoan, M.D., a past president of the CPA, wrote in Viewpoints in

please see ***California*** *on page 6*

Hundreds Walk Pennsylvania Avenue To Raise Mental Illness Awareness

On a crisp, cool day in early November, APA members and staff marched to the U.S. Capitol in solidarity with other mental health advocates to raise awareness of mental illness.

BY EVE BENDER

APA leaders and staff were among the hundreds of mental health advocates who donned their walking shoes on November 6 for the first 5-K walkathon sponsored by the National Alliance for the Mentally Ill (NAMI) in the nation's capital.

Each year, NAMI organizes as many as 50 walks, called NAMIWalks, in major cities throughout the United States, which are designed to raise funds for advocacy, education, and research initiatives related to mental illness.

For the D.C. NAMIWalk, APA, the American Psychiatric Foundation (APF), and American Psychiatric Publishing Inc. (APPI), supported the walkathon through a combined contribution of $20,000 *(Psychiatric News*, November 5). APA was a presenting sponsor at $10,000, and APF and APPI were gold sponsors at $5,000 each.

The morning walk began with a rally on Freedom Plaza, which is located across the street from the J.W. Marriott Hotel, the site of APA's fall Assembly meeting (see page 14).

Dozens of Assembly members streamed out of the hotel and into the brilliant sunshine to take their place on Freedom Plaza. There, they joined "Team APA," which, in addition to other APA leaders and staff, included friends, family members, and one dog. Through the fundraising efforts of its members, Team APA contributed nearly $3,000.

"Our communications efforts at APA resulted in having many APA employees and a number of APA members attend the inaugural D.C. NAMIWalks march," said Eugene Cassel, director of APA's Division of Advocacy. "We are pleased to have also provided financial support for an event that we hope will continue as a wonderful tradition."

APA President-elect Steven Sharfstein, M.D., reminded walkers that "APA loves NAMI" and said the two organizations would continue to work together to finish "overdue, unfinished business," including the elimination of racial and ethnic barriers to receiving treatment for mental illness and boosting funds for research that will produce more effective treatments for psychiatric disorders.

James Nininger, M.D., speaker of APA's Assembly, rallies the troops. He emphasized the shared goals of NAMI and APA.

Sharfstein said NAMI "proves that people can make a difference," and since the organization began 25 years ago, it "has provided hope for people with serious and persistent mental illness and their families."

"Together we must overcome the resistance and inertia in the House of Representatives to get the Wellstone parity act passed now," he declared. He was referring to the Sen. Paul Wellstone Mental Health Equitable Treatment Act.

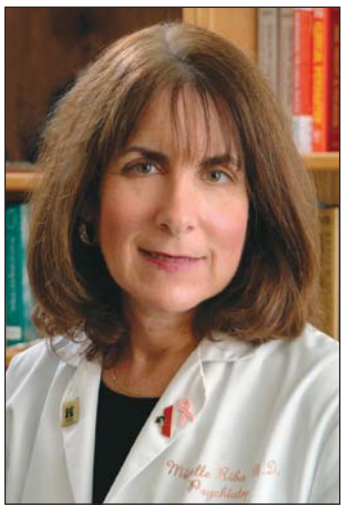
James Nininger, M.D., speaker of APA's Assembly, also emphasized the shared goals of the two organizations.

"It seems appropriate that our meeting coincides with this walk," he said. "Both events are designed to move the field of mental health forward and advocate for treatment and support for patients and their families."

please see ***Walk*** *on page 43*

APA to Launch MH Initiative For College Students, Families

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



Living and working in a college town, I have become accustomed to some of the seasonal events related to the students' arrival in late summer—calls from parents, friends, friends of friends, and colleagues who are trying to determine who should provide psychiatric care to their students/patients. Similarly, around November and December I get calls concerning students who did not seek care in the beginning of the fall semester, but are starting to experience psychiatric difficulties as academic pressures build.

College life for many students is a breeding ground for psychiatric problems, fed by alcohol and substance use, decreased sleep, stress, being away from family and perhaps far from familiar surroundings, absence of parental rules, changes in eating and living situations, peer pressure, classroom and study pressure, changes in exercise patterns and participation in organized sports, and so on.

We also often see students who have had major psychiatric problems—eating disorders, bipolar disorder, anxiety and mood disorders—and come to college hoping that somehow the change in environment and being away from home will help keep them well. We also know that the late teens and early 20s are ages when new psychiatric problems, such as schizophrenia, may develop.

Only recently has the subject of college students' mental health begun to get serious press. The article "The Dorms May Be Great, But How's the Counseling?" in the October 26 *New York Times* pointed out that one criterion in choosing a college should be access to mental health care. The proliferation of suicide on college campuses has also been in the news throughout the country. According to the Substance Abuse and Mental Health Services Administration, suicide is among the three leading causes of death of young people between the ages of 15 and 24.

The parents of one college student who committed suicide—Garrett Smith—took an important step that may prevent similar tragedies from occurring in other families. His father, Sen. Gordon Smith of Oregon, introduced the Garrett Lee Smith Memorial Act in Congress only a few months ago, and it was signed by President Bush last month *(Psychiatric News*, November 19). This legislation provides federal funding for suicide-prevention services, particularly those directed at youth.

Often mental health clinics on university campuses are set up to provide psychological and social work services rather than psychiatric care. Psychiatrists are sometimes available only on a limited basis, and the insurance benefits for mental health care that a family has at home may not translate into private, fee-for-service psychiatric care in the college town where their student is studying.

Why am I raising these issues? I believe there is an important role for APA to assume in helping facilitate the provision of high-quality mental health services and education on college campuses. Working with our colleagues in a multidisciplinary, broad-based coalition including the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, American Academy of Addiction Psychiatry, AMA, American College Health Association, American College Counseling Association, National Mental Health Association, National Alliance for the Mentally Ill, and others, we can develop prevention programs and materials; identify a better and more systematized way to provide referrals, support, and appropriate care for students; and continue our work to decrease the stigma of mental illness.

At the University of Michigan, where I am on faculty, we have been holding yearly "Depression on College Campus" symposia, featuring such experts as Thomas Insel, M.D., director of the National Institute of Mental Health, and Nora Volkow, M.D., director of the National Institute on Drug Abuse, to highlight the importance of good mental health care for students. We also have a university-wide task force that is determining how to better provide such care to students and educate them about mental health issues, as well as provide information to families so that they can identify when their student may need professional intervention and help them obtain it.

For APA to provide a leadership role on this issue, we must determine the extent of the problem; identify the stakeholders in local, regional, and national efforts; identify or develop model programs and the resources necessary to implement them; identify the roadblocks to implementation (such as financial problems); and develop evaluation programs so that we can make our efforts more effective.

A good starting point is our district branches and state associations—they are well positioned to work with colleges and universities and help provide an important link in this very important, yet vulnerable period for students and their families.

In the next few weeks, I will be appointing APA members to a work group on college mental health. I very much welcome your suggestions and thoughts on this subject. Please e-mail me at mriba@umich.edu. In a future column, I will summarize what I learn from you and outline a strategy for APA to follow on this crucial issue. ■

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

Association News

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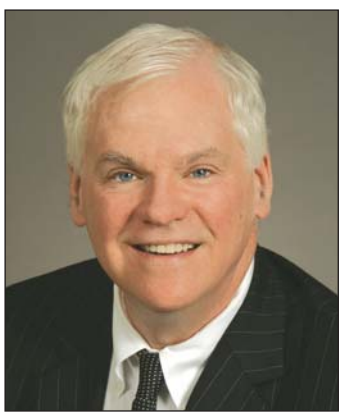
APA Office Helps Members Negotiate Managed Care Concerns

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



Under the direction of Irvin "Sam" Muszynski, J.D., APA's Office of Healthcare Systems and Financing (OHSF) works on both policy issues that affect psychiatry as a whole and practical issues that are of concern to individual psychiatrists. Not surprisingly, these issues often overlap.

Last year we became aware of problems with documentation for Oxford Health Plans through calls that came to the Managed Care Help Line from APA members in New York who were requesting help in complying with an Oxford audit on mental health services. Recently Oxford announced that it had approved a documentation template for psychiatry that adheres to the privacy rule set forth in the Health Insurance Portability and Accountability Act (HIPAA) and the requirement that only minimally necessary patient information be released to insurers for claims audits.

As a result of intervention by Seth Stein, J.D., executive director of the New York State Psychiatric Association (NYSPA), and APA, not only did Oxford agree to the meetings that established the recently finalized template, but also the results of the audit were invalidated, and all requests for the return of monies based on insufficient documentation were rescinded. APA and NYSPA were involved in the development of the new template over the past year, and both were involved in drafting the document eventually agreed to by Oxford and other mental health associations involved with the negotiations. We hope that this template will serve as a model for the insurance industry on how patient confidentiality can be maintained even when claims audits are required. More information about these developments will be reported in greater length in a future issue.

As was the case with the Oxford audit, the OHSF's Managed Care Help Line serves as a meaningful and convenient tool for communicating concerns and recommendations. This toll-free line, managed by Karen Sanders, offers help to APA members on payment and documentation issues when dealing with insurers. The top five issues for which members call for help are practice software, claims nonpayment, opting out of Medicare, confidentiality relating to HIPAA, and legal/contracting problems.

APA members can call the Managed Care Help Line at (800) 343-4671 or e-mail their comments to hsf@psych.org.

Issues referred to the OHSF are reviewed on a case-by-case basis. Staff have been effective in solving problems through the working relationships they have established with medical directors of managed care organizations and Medicare carriers. Problems that seem insoluble to individual APA members can often be resolved because our staff have access to the people who can cut through the red tape. They are also able to do the legwork that individual psychiatrists and their staffs often don't have time to do. Although we may not always prevail, we have a solid record of facilitating helpful resolutions.

The OHSF also deals with issues that affect individual psychiatric practices, but are clearly policy issues that need to be approached on the national level. For instance, Rebecca Yowell, OHSF's assistant director, serves as APA's staff liaison to the AMA's Current Procedural Terminology (CPT) Editorial Board, which establishes medical procedure coding, and the Relative Value Update Committee, which establishes the work values of medical procedures. While these work values are established for Medicare, they are used by private insurers to make payment policy as well. APA's involvement in this area is especially critical at the moment, since recent proposals for changes have raised scope-of-practice issues for nonphysician practitioners.

Currently, the office is engaged in discussions with Magellan Health Services about eliminating the hold-harmless clause it includes in its contracts with network physicians. APA members have been informed about the dangers of signing contracts with these clauses, and Magellan is now the only major behavioral health managed care organization that still includes this provision in its contract.

The OHSF was also involved in helping formulate APA's comments on the proposed Medicare drug benefit *(Psychiatric News*, November 5). This was done in concert with the National Alliance for the Mentally Ill, the National Mental Health Association, and the National Association of State Mental Health Program Directors to ensure that Medicaid patients throughout the country have access to appropriate psychotropic medications and proved to be invaluable in approaching the new issue of access to medications under Medicare.

In addition, OHSF staff continue to promote important workplace mental health tools like the depression calculator, posted online at <www.depressioncalculator.com>. It enables employers to assess the fiscal impact of untreated depression on their company's bottom line. OHSF staff member Clare Miller heads APA's Business Initiative and has been instrumental in developing materials on depression for businesses to distribute to their employees.

OHSF staff member Ellen Jaffe is responsible for the popular "Practice Management for Early Career Psychiatrists." Thanks to new technology, we are now able to offer downloadable versions of each chapter from the APA Web site. This and other resources, such as the *CPT Handbook for Psychiatrists* and *Psychiatric Practice and Managed Care*, provide valuable and practical information for members.

Other staff members include administrative assistants Mary Ward Rohweder and Samantha Hawkins.

This work is an example of how our staff assists members with resolutions on policy issues that affect their daily practice and patient services.

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

Priority Hotel Reservations for APA Members

During December, APA members 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.

Hospitals Wait to See New Payment System's Effects

Inpatient psychiatric facilities have operated outside Medicare's prospective payment system since the system began a little more than 20 years ago. That exemption is now ending.

BY MARK MORAN

Prospective payment has come to inpatient psychiatry. Last month the Centers for Medicare and Medicaid Services (CMS) published a final rule implementing a new prospective payment system (PPS) for the nation's inpatient psychiatric facilities. The new system will go into effect for payment periods beginning on or after January 1, 2005.

The new rule implements a per diem system of prospective payment—as opposed to the per-case system using diagnosis-related groups (DRGs) that has been in place for many other health care facilities since 1983—with daily rates adjusted for a host of factors that can influence the cost of care. The rule marks the end of the two-decade exemption for psychiatric facilities from prospective payment under Medicare.

> "The major point is that the methodology we developed does not place another major administrative burden on the hospital or the clinician."

Since that time, facilities offering psychiatric services were paid instead using a cost-based system under rules established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

APA leaders emphasized the landmark nature of the shift to prospective payment, a change that will entail the redistribution of billions of federal dollars for inpatient care of patients with psychiatric disorders.

"The new prospective payment system is an important step forward in payment for inpatient psychiatric care under the Medicare program, as the TEFRA payment method has proven problematic for many providers," said APA President-elect Steven Sharfstein, M.D.

Joseph T. English, M.D., a leader in APA's negotiations with the government around reimbursement for inpatient psychiatry for the past two decades, said APA has been heavily involved in working with the government to develop a workable system of prospective payment for inpatient psychiatry.

He noted that APA has also partnered with the Health Economics and Outcomes Research Institute (THEORI), a consultant group linked to the Greater New York Hospital Association, in developing a method of data collection for reimbursement under the new system that relies on existing Medicare claims data.

That method replaces a government proposal that would have required psychiatric hospitals to use a lengthy, costly, and time-consuming "new patient assessment" instrument to collect data.

"The major point is that the methodology we developed does not place another major administrative burden on the hospital or the clinician," English said. "It means that hospitals that provide psychiatric services will be reimbursed by a method that allocates resources fairly and based on information that the hospital already collects."

He is a past president of APA and current chair of APA's Committee on Reimbursement for Psychiatric Care. He is also chair of the Mental Health and Substance Abuse Committee of the Greater New York Hospital Association, as well as chair of psychiatry at St. Vincent Catholic Medical Centers and professor and chair of psychiatry at New York Medical College.

It was English who led the effort two decades ago to exempt inpatient psychiatry from prospective payment based on the system of DRGs used for general hospitals and other health care facilities. That exemption spared hospital-based psychiatry a reimbursement system that would have cost the hospitals roughly $200 million a year in lost funding, or $4 billion over the 20-year period, English told *Psychiatric News*.

English noted that the redistribution of resources under the new payment system will mean, invariably, that there will be winners and losers. Exactly how the new system will affect individual hospitals remains to be seen, however.

An analysis of the new rule is being conducted by APA's Office of Healthcare Systems and Financing, the APA Committee on Reimbursement for Psychiatric Care, and THEORI. When the review is complete, a report on how the rule may affect hospitals in general will appear in *Psychiatric News*.

During the first cost-reporting period after the rule goes into effect in January, hospitals will receive a 25 percent/75 percent blend of PPS and TEFRA payment methodologies, with a staged increase in prospective payment until July 1, 2008, by which time all hospitals will be reimbursed under the new PPS.

The final rule includes the following key provisions, according to a preliminary reading by APA's Office of Healthcare Systems and Financing:

• **Emergency department adjustment:** A 12 percent payment increase on the first

please see ***Hospitals*** *on page 46*

California

continued from page 1

the September 3 issue of *Psychiatric News*, "The scope of the program and its tax-the-rich source will provoke a debate. But it's an argument worth having to make California face the neglect of not providing treatment to more than 1 million people with mental illness."

He pointed out that a California legislative analyst estimated "savings of hundreds of millions of dollars annually on a statewide basis from reduced costs for state prison and county jail operations and medical care, police activities, shelters, and social service programs for the homeless."

Shadoan told *Psychiatric News*, "We are very grateful for APA's early endorsement of Proposition 63, its contribution of $25,000 to support the initiative, and to psychiatrists around the country who made contributions in response to the Viewpoints article."

The five district branches in California together raised about $50,000, he said.

How Did They Win?

State Assemblyman Darrel Steinberg (D) showed tireless and effective leadership in the battle to pass Proposition 63, according to CPA members. He has a long-standing commitment to funding for mental health care (see facing page).

The CMH turned to well-known tools of successful political strategists and also adopted innovations, such as use of the Internet, to create support.

Early in 2003, organizers hired an opinion research and public policy analysis firm to conduct focus groups to gauge reaction to the initiative (*Psychiatric News*, January 2, May 7).

Among the conclusions of the firm, Fairbank, Maslin, Maullin, and Associates, was that the "severely mentally ill evoke the most sympathy and compassion from voters. . . . Even more cynical voters who doubted the measure's means, merits, and objectives did not question the need to provide seriously emotionally disturbed children with [treatment]. . . . Voters want a proven model."

Organizers emphasized the idea that the new effort was modeled on California AB 34, a pilot program approved in 1999 that funds services to mentally ill adults who are homeless or at risk of becoming homeless or incarcerated. The New Freedom Commission on Mental Health cited it as a model program.

The CMH formed a broad coalition of organizations that together represent a number of different constituencies.

In addition to state and national medical and mental health associations, the CMH includes six major California unions and organizations such as the California Teachers Association, AARP-California, and the California Police Chiefs Association (CPCA).

CPCA President Cam Sanchez wrote in a letter to the *San Diego Union-Tribune*, "Police chiefs like me face an awful reality: 20 percent of our officers' time is spent dealing with untreated mental illness. Too often, we must take people with mental illness to jail, not because they have done anything wrong, but because there is nowhere else to go. . . . Proposition 63 will finally make mental health care a priority and free law enforcement to spend more of their time and resources on public safety rather than our failed mental health system."

City councils in Los Angeles, Oakland, Santa Barbara, and Santa Monica supported the initiative, as did the San Francisco Board of Supervisors.

The CMH gathered more than 600,000 signatures, nearly double the number required to qualify the initiative for the ballot.

Advocates could turn to the Web site <www.campaignformentalhealth.org> for updates on progress, as well as for an extensive array of information to help the organizing process. There were suggestions on hosting events and targeting groups, an opportunity to donate online, and facts and analyses that could be used in advocacy. Steinberg even hosted a daily blog in which advocates shared ideas.

Sympathetic stories in major newspapers portrayed the impact of the failed mental health system and described lives that had been reclaimed by treatment.

An organized opposition developed after a poll found support for Proposition 63 at 64 percent. Gov. Arnold Schwarzenegger (R) came out against the proposition.

David Yow, a spokesperson for a campaign against the measure, argued, "While there is a great idea behind it, this measure is a desperate substitution for an actual solution. It takes an important social program and ties it to a funding source that is really a narrow slice of taxpayers," according to the October 22 *San Francisco Chronicle.*

Proposition 13, passed in California in 1978, restricted increases in property taxes and required that all state tax increases be approved by a two-thirds vote of the state legislature. Because of the difficulty of securing that vote, advocates for various causes have turned to the use of propositions or "ballot-box budgeting" to raise revenue.

Advocates of Proposition 63 argued that although such a strategy is not an ideal method, the importance of the initiative took precedence.

Implementation Will Be Key

Shadoan believes that the "job is only half done" with the initiative's passage. He said, "Psychiatrists and other mental health practitioners now must work to make certain that the funds are expended in a cost-effective manner on high-quality treatment."

He will chair the Proposition 63 Implementation Task Force of the CPA.

Maintaining quality in implementation will be important to ensure public trust and establish accountability, Shadoan continued. In addition, advocates in other states will look to California for evidence that can be used to support similar initiatives.

"The impact of this initiative goes far beyond California," he observed.

More information on Proposition 63 is posted at the CMH's Web site at <www.campaignformentalhealth.org>. ■

Lawmaker's Crusade Boosts MH Funding

What does it take to reverse the trend of shrinking mental health dollars? Begin with the view that "everyone knows someone with mental illness," says California legislator Darrel Steinberg.

BY KATE MULLIGAN

In California, a state famed for the size of its budget deficit, voters passed Proposition 63, a ballot initiative that is estimated to result in $700 million in new money for mental health services each year (see page 1).

Members of the California Psychiatric Association (CPA) give a great deal of credit for that victory to Assembly member Darrel Steinberg (D).

Steinberg, in turn, attributes success to the fact that "everyone knows someone with mental illness. It is not about 'those people.' "

He added, "Mental illness is one of the long-ignored issues in society, but the irony is that it's personal to more people than we imagine."

"[We ran] a great campaign," he said. "And, unlike many other good causes, we were also able to strike a chord with the voters."

Steinberg said he learned from traveling around the state campaigning for the initiative that there was general knowledge that Ronald Reagan, as the state's governor, had shut down many of the state mental hospitals in the 1960s.

"Residents see the consequences of that decision every day in terms of homelessness and other social problems," he said.

The Campaign for Mental Health, which led the battle for the initiative, emphasized the idea that Proposition 63 would be a remedy for the state's broken promises to people with mental illness.

Steinberg is completing his third term representing the 9th Assembly District, which includes most of the city of Sacramento. He became interested in the issue of mental illness when serving on Sacramento's City Council in 1996. The city sued a charity serving homeless people for violating a law concerning limitations on providing meals on Sunday.

APA Assembly Speaker Al Gaw, M.D. (left), presents California Assembly member Darrel Steinberg with a Speaker's Award at last year's annual meeting in San Francisco in recognition of his support on mental health issues.

The case, which attracted national media attention, was really about the city's frustration with dealing with homelessness, said

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Small Steps Could Be Key To Reforming Medicaid

Governors recognize a host of problems with the Medicaid program, particularly with finding dollars to fund it, and suggest small-scale efforts by state governments to bring about reform.

BY KATE MULLIGAN

Governors are advocating the power of "common-sense principles" to maintain the viability of the Medicaid program.

Matt Salo, director of the Health and Human Services Committee of the National Governors Association, told attendees at a meeting on prospects for Medicaid reform, "I want to reassure people that. . .we do not have a Medicaid reform agenda, or proposal, or clandestine work group trying to figure out how best to deal with Medicaid."

He pointed out that for about 10 years, "every year, every other year, states [were] looking at some kind of grandiose design for Medicaid reform. . . ."

America's Health Insurance Plans, a national trade association for insurance companies, sponsored the October 21 meeting.

Salo went on to describe key issues and emerging problems for the program. A primary problem for state budgets is "dual eligibles," people who are eligible for both Medicare and Medicaid benefits. Although the group is only about "6 to 7 million people out of the universe of 50 million in Medicaid," about 42 percent of the Medicaid budget is directed to them. The population is composed of "low-income, frail seniors and some adults with disabilities."

The biggest issue, according to Salo, is a "very hidden one." Medicaid has become the de facto payment system for long-term care. About 70 percent of people in nursing homes receive care financed by Medicaid at some point. The problem will get "worse and worse and worse," as the baby boomers age, he said.

Salo spoke in favor of state-based health care demonstrations because of the difficulties of large-scale reform at the federal level.

He listed items including improving patient safety in hospitals and increasing use of technology such as electronic prescribing and medical records.

Amy Hall, minority staff member of the House of Representatives' Committee on Energy and Commerce, argued in favor of legislation that would increase the federal contribution to Medicaid during economic downturns. Currently, when states' budgets are tight, they are also faced with an increase in the number of people eligible for Medicaid.

Hall pointed out that President George W. Bush twice had proposed turning Medicaid into a block-grant program and likely would return to the idea (*Psychiatric News*, September 5, 2003).

She also said there will be increased emphasis on cutting "fraud and abuse" from the program, but that there are unrealistic assumptions about how much money can be saved.

Hall and Salo both mentioned that the federal government is challenging various financing mechanisms used by states to reach their match for funds.

Salo charged, "What they are doing right now is going into states and just denying completely unrelated waivers, . . . state plans, state plan amendments, state plan renewals, until they can find a way to change the way they're financing the program."

Rep. Heather Wilson (R-N.M.) chairs the House Committee on Energy and Commerce's Task Force on Medicaid Reform. She described her perception of problems with the Medicaid program to *American Medical News* reporter Joel B. Finkelstein and was quoted in the July 19 issue.

Wilson said the financing mechanism is a "joint state-federal operation that results in these Rube Goldberg schemes for states to shuffle money around and draw down more federal dollars."

She also said that the program was "not set up to improve anyone's health," but is instead an insurance-claims payment system.

Wilson expressed concern about the program's lack of flexibility and acknowledged that reimbursement rates have limited access to physicians.

She said, "We're going to try to move toward a comprehensive Medicaid reform bill. . . . The big problems with Medicaid are just that—big problems—and so we have to come up with comprehensive solutions and at least get them on the table."

Changes to Medicaid could have serious consequences for mental health, according to Michael Hogan, Ph.D., director of the Ohio Department of Mental Health and chair of President Bush's New Freedom Commission on Mental Health.

He told *Psychiatric News*, "Medicaid has become the leading single payer of treatment for adults and children with serious mental illness."

Hogan cautioned, "Mental health considerations must be explicitly and carefully considered in Medicaid reform or there will be problems. There is a very uneven history at best of weighing mental health needs in the Medicaid program at the national and state levels."

"Prospects for Medicaid Reform" is posted at <www.kaisernetwork.org/health_cast/uploaded_files/102104_ahip_prospects_transcript.pdf>. ■

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Psychiatrists Learn to Argue For Treatment of Offenders

Long-term data will be valuable in convincing policymakers about the effectiveness of treatment rather than incarceration for people with mental illness.

BY MARK MORAN

Treatment of mental illness in the community, rather than in the criminal justice system, can save communities and local taxpayers money over time.

But reversing the widespread criminalization of mentally ill people requires an educated cadre of clinicians to make the case before legislators that diversion of individuals with mental illness from jails and prisons and into treatment in the community is the right thing to do.

And it will also require long-term follow-up studies to prove the point.

That was the message that psychiatrists took home last month from a conference in Washington, D.C., titled "Effectively Approaching Elected Officials on Shifting Resources to Community-Based Services for Persons With Mental Illness in Contact With the Justice System."

The day-long forum was cosponsored by APA, the TAPA Center for Jail Diversion, and the Council on State Governments (CSG). It was a follow-up to an expert conference convened on the subject in February by then APA president Marcia Goin, M.D. *(Psychiatric News*, March 19).

Goin and APA President-elect Steven Sharfstein, M.D., were part of the policy forum's panel of experts, which also included A. Kathryn Power, director of the federal Center for Mental Health Services, and Michael Thompson, director of Criminal Justice Programs at the CSG. In addition, representatives from 10 APA district branches (DBs) were flown in to attend the conference, with all their expenses for the conference paid by the TAPA Center.

Goin told *Psychiatric News* that last month's conference was part of APA's continuing commitment to reverse the trend to incarcerate people with mental illness—an issue she made a priority during her presidency. She said the TAPA Center invited the DB presidents with the goal of providing practical tools for representatives from some of APA's largest DBs to return home and begin advocating for diversion from the criminal justice system and for treatment in the community.

"This collaboration with the Council on State Governments and with TAPA helps to lead the way in a very practical sense to effective advocacy in our state legislatures for resources being directed toward treatment of patients, not incarceration," she said.

At the conference, Thompson, of the CSG, presented practical information on how to successfully approach legislators about the value of spending money for diversion rather than imprisonment, stressing the importance of forging alliances with the criminal justice and corrections communities.

Henry Weinstein, M.D., chair of APA's Corresponding Committee on Jails and Prisons, presented an APA Resource Kit on Criminalization of the Mentally Ill that included, among other items, APA's Guidelines on Psychiatric Services in Jails and Prisons, APA's Fact Sheet on Criminalization of People With Mental Illness and Jail Diversion, as well as the proceedings of the February conference convened by Goin.

Weinstein said that the issue is an urgent one and that those psychiatrists who attended last month's conference were in the "vanguard" of the movement to reverse the criminalization of the mentally ill.

"As everyone knows, there are more mentally ill housed in jails and prisons these days than there are in psychiatric hospitals," Weinstein told *Psychiatric News.* "This is a very important population for APA to focus on, and at this conference we turned our attention to funding community services for this population at the 'front door' through diversion programs before people enter the criminal justice system, and at the 'back door,' when they leave the system and re-enter the community."

Critical to persuading local policymakers about the justice and effectiveness of treatment rather than incarceration are long-term follow-up data from communities that have diversion programs in place.

Henry J. Steadman, Ph.D., director of the TAPA Center for Jail Diversion, told psychiatrists that existing data indicate that, in the short term, treatment in the community is liable to be as, or even more, expensive than incarceration and that savings may not accrue until as long as 18 months later when patients have been stabilized.

"The current thinking is equivocal about the cost savings, in the short term, from jail diversion programs," Steadman told *Psychiatric News.* "When you provide appropriate and comprehensive community-based services for people who are diverted from the criminal justice system, costs over the first year are about the same as if they had stayed in the criminal justice system.

"But as you get into the 14- to 18-month period, you begin to see cost savings," he continued. He referred to research using simulation models comparing costs of treatment in the community with those of incarceration. "This is not surprising, given the chronic nature of the illnesses in this population."

please see ***Offenders*** *on page 44*

Expert Witness Describes Making of a Serial Killer

A forensic psychiatrist shares what she learned about a young man with a turbulent past who was gradually molded into part of a killing team by the man he trusted the most.

BY EVE BENDER

A childhood marred by abuse, neglect, and the absence of a father figure rendered Washington, D.C.-area sniper Lee Malvo susceptible to brainwashing techniques that enabled him to kill without emotion, according to a psychiatrist who examined Malvo before his trial.

Diane Schetky, M.D., who served as an expert witness for the defense at Malvo's 2003 trial, quoted him as saying of convicted sniper John Muhammad, "Anything he asked me to do I'd do. He knew I didn't have a father. He knew my weaknesses and what was missing."

Schetky, who is a clinical professor of psychiatry at the University of Vermont College of Medicine, appeared at the annual conference of the American Academy of Psychiatry and the Law in Scottsdale, Ariz., in October to share what she learned about Malvo during two interviews with him.

Malvo was born in Kingston, Jamaica, in 1985 to Una James. His father, Leslie, doted on his young son, according to Schetky.

Leslie Malvo worked off-island, and during his long absences, Malvo was "inconsolable," Schetky said.

James suspected Leslie of infidelity and moved with her son to a small, rural part of Jamaica without telling him where they had gone. "Lee was devastated by the loss of his father," she noted.

Violence Characterizes Boyhood

It was around this time that James began to take her rage out on her son, according to Schetky, by beating him with switches, brooms, and belts.

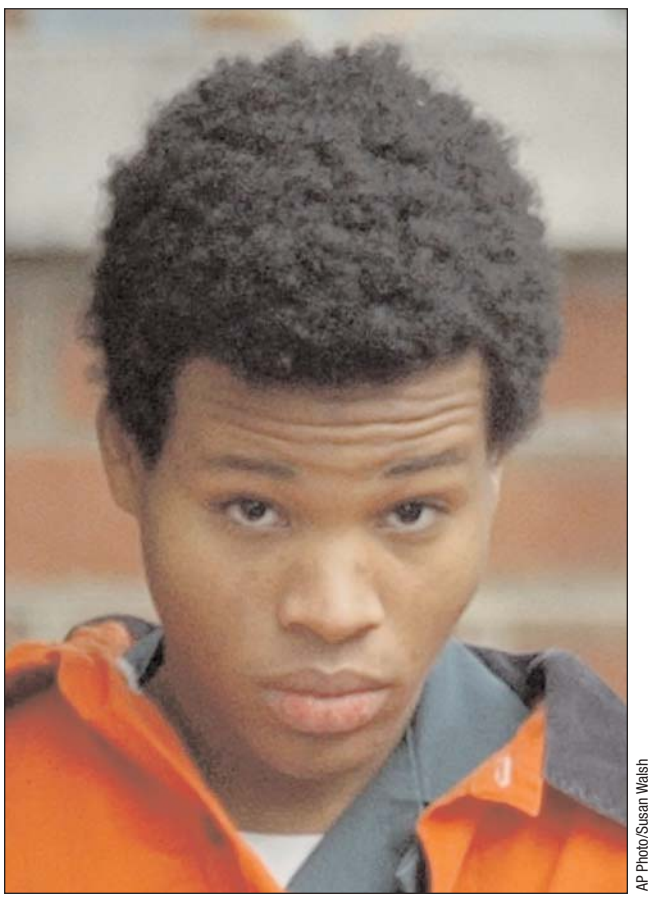
"Lee responded to the abuse by being compliant," Schetky said. "He learned that if he put himself in a trance, the corporal punishment didn't hurt as much."

In addition to being a victim of violence, he was a witness, too. At age 7, while walking to school alone, Malvo saw a man killed by assailants. "At a later age he was grazed by a bullet himself on the streets of Kingston," Schetky said.

Malvo's cousin was also murdered when Malvo was a young boy.

When Malvo was 8, James left Jamaica to obtain work, and Malvo began a series of transient placements. He had attended 14 schools by the time he was in high school, she noted, and had infrequent contact with his mother until he moved to Antigua as a young teenager to be with her.

Together they lived in a shack with no electricity or plumbing until James moved out for a period of eight months, leaving her son to fend for himself.



AP Photo/Susan Walsh

Expert defense witness Diane Schetky, M.D., described Lee Malvo (above) as "putty in John Muhammad's hands." Malvo is shown in a file photo from December 30, 2002, as he is escorted out of Fairfax County Juvenile and Domestic Relations Court after a hearing.

Indoctrination Process Begins

Malvo was 15 and longing for a father-figure when he met John Allen Muhammad in Antigua.

The teenager admired how caring Muhammad seemed with his own children, Schetky said, and they formed a bond that progressed to the point where Malvo referred to Muhammad as "dad," instead of "sir."

According to Schetky, Muhammad began putting his newest charge through intense physical-fitness drills and converting him to "Muhammad's version of Islam," she said, in which the federal government was the enemy of black people.

Muhammad gave Malvo tapes, books, and lectures on the history of the oppression of blacks around the world.

During this time, "Lee complied with the indoctrination and never questioned Muhammad," Schetky noted.

Once in the United States, Malvo and Muhammad lived together in Bellingham, Wash., where Muhammad subjected Malvo to survival training. "Lee would be tied up in the woods for hours wearing only shorts and learned to go without food and sleep," she said.

Muhammad also taught Malvo that "emotions were the enemy and a sign of weakness," Schetky said.

As far as Malvo knew, the indoctrination and survival training were preparation for a mission during which they would steal money to establish a utopian community in Canada, where they would live with children from minority ethnic groups.

Malvo soon learned this mission would require killing, which began two days short of Malvo's 17th birthday in February 2002 in Tacoma, Wash. As a test of Malvo's allegiance to Muhammad, he shot Keenya Cook, 21, in the face, killing her.

Schetky said Malvo had a "visceral response to the killing and was pretty shaken."

Malvo Has Second Thoughts

According to Schetky, Malvo began to "waver" shortly before the D.C.-area sniper spree that would claim the lives of 10 people during October 2002. "He slowly realized Muhammad was not making the world a better place" and was "angry, depressed, not sleeping, and confused," Schetky said.

At one point Malvo put a loaded gun to

please see ***Serial Killer*** *on page 44*

'Special Chemistry' Forges Bond Between Killing Teams

When people kill in pairs, it is not unusual for one of the killers to play a dominant role in the relationship, according to an expert on serial murder.

BY EVE BENDER

Behind the monikers—the D.C. Snipers, the Hillside Stranglers, the Sunset Strip Killers—are two people who meet and develop a "special chemistry" that moves them to rape, torture, or kill together.

This chemistry "seems to ignite the team's willingness to engage in the most despicable behavior, which they might never have engaged in separately before they met and established a bond of loyalty," noted Jack Levin, Ph.D., who is the Irving and Betty Brudnick Professor of Sociology and Criminology and director of the Brudnick Center on Conflict and Violence at Northeastern University in Boston.

Levin, who is also an expert on serial killers, spoke at the annual meeting of the American Academy of Psychiatry and the Law in Scottsdale, Ariz., in October about the dynamics between two people who kill.

As it was with John Muhammad and Lee Malvo (see story above), there is usually a dominant partner who persuades the other person to kill and who is somewhat older then the other person.

This was also the case with Angelo Buono, who was in his 40s when his younger cousin, Kenneth Bianchi, came to Los Angeles from Rochester, N.Y., to live with him in 1975.

Buono convinced his 27-year-old cousin they should get teenage girls to prostitute for them, which they did. Their first victim was Yolanda Washington, one of these prostitutes.

Ultimately, the cousins would go on to torture, rape, and kill 14 girls in the Los Angeles area.

Levin noted that with each victim, the level of sadism increased to the point where the cousins electrocuted their victims or injected them with cleaning fluid. "They got high on sadism and needed larger and larger doses to keep that high," he said.

Doug Clark and Carol Bundy met and fell in love in Los Angeles in 1979, and Clark convinced Bundy to lure an 11-year-old neighbor to Clark's apartment so he could photograph her nude. Bundy said later that the child was her "gift" to Clark. Together, the pair killed and mutilated at least seven women along the Sunset Strip.

In a later case, 23-year-old Paul Bernardo convinced his 17-year-old girlfriend, Karla Homolka, to help him rape, torture, and kill three young girls—one of them being Homolka's younger sister—in Toronto in the late 1980s.

"I would argue that the insanity in these cases lies in these relationships more so than it does in the killers' individual minds," Levin said. ■

Popular Strategies Often Fail to Reduce Violence

An interdisciplinary panel of 13 experts met at the National Institutes of Health (NIH) last month to decide what type of programs prevent youth violence or other risk-taking behaviors, according to an NIH draft conference statement.

The panel found that group detention centers, boot camps, and other "get tough" programs often "do nothing more than provide an opportunity for delinquent youth to negatively influence each other. Similarly, state laws that facilitate the transfer of juveniles to the adult judicial system are often counterproductive, resulting in greater violence among incarcerated youth."

The panel found that in randomized controlled trials, several programs were effective in reducing arrests and out-of-home placements. Common characteristics of the successful programs were a focus on developing social competency skills, a long-term approach, and family involvement.

The panel made several recommendations including the creation of a national population-based violence registry and greater emphasis on economic research into the cost-effectiveness of intervention to prevent violence, the panel's statement noted.

A summary of the report, "Evidence Report on Preventing Violence and Related Health-Risking Social Behaviors in Adolescents," is posted online at <www.ahrq.gov/clinic/epcsums/adolvisum.htm>. The "NIH Conference Statement on Preventing Violence and Related Health-Risking Social Behaviors in Adolescents" is posted online at at <http://consensus.nih.gov/ta/023/youthviolenceDRAFTstatement101504.pdf>. ■

Assembly Members Tackle Wide-Ranging Agenda

Several key issues related to patient care had a prominent place on the Assembly's agenda last month, but a substantial part of formal and informal discussion was on the fate of one state's new structure for organized psychiatry.

BY KEN HAUSMAN

While APA Assembly members deliberated a variety of issues at their November meeting in Washington, D.C., the future of organized psychiatry in Texas was the topic of much discussion during the plenary sessions as well as during Area Council meetings and informal discussions.

Richard Kaye, D.O., wins the APA Assembly's 2004 Profile of Courage Award for his fight against Virginia's plan to close inpatient beds at state psychiatric facilities. Kaye feared the plan would leave many indigent patients without access to treatment for serious mental illness and increase the number of people with mental illness who end up in jails and prisons. "I never thought that patient advocacy would become a major part of my practice," Kaye said.

Assembly Speaker James Nininger, M.D., set aside an hour after the first plenary session ended to provide a forum in which members could quiz the Texas representatives about the details and impact of a controversial restructuring for organized psychiatry in that state that has drawn substantial opposition from both the Board and Assembly (*Psychiatric News*, November 19).

Later in the three-day meeting, the Assembly voted to ask the Board of Trustees, which meets later this month, to hire an independent mediator, at an estimated cost of $12,000 to $15,000, to see whether Texas district branch and APA leaders can reach some agreement that would satisfy both sides of the dispute. The Assembly chose that option over doing nothing, supporting the Texas "experiment," or allowing the Board of Trustees to "de-link" the Texas district branch from APA and replacing it with a new district branch.

The Assembly also passed several action papers concerning patient-care issues.

The members voted, for example, to support federal legislation or regulatory efforts to eliminate a 30-patient limit on the number of opioid-dependent patients that can be treated with buprenorphine in an outpatient practice. The representatives were not persuaded by arguments that removing the limit could lead to the establishment of "prescribing mills" by physicians who passed the mandatory buprenorphine-prescribing course but had little other addiction treatment experience.

They also backed a proposal that urges APA to "develop and regularly update procedures to apply the principles of medical necessity to the practice of psychiatry." The action paper states that the motivation underlying the proposal is the belief by some members that APA is not adequately monitoring how managed care companies are defining medical necessity and applying their definitions to coverage decisions. This calls on APA to take a more "proactive" role and meet more often with insurers about their medical necessity principles and with district branches about their efforts to deal with insurers in setting medical necessity standards for psychiatric care.

Nininger also devoted one plenary session to workforce issues in psychiatry. The presentations will be described in the next issue of *Psychiatric News*.

In other actions, the Assembly voted to

- **have APA explore whether to develop criteria for the diagnosis of bipolar disorder in children that would be included in the next edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.** The authors noted a substantial increase in the last few years of articles and presentations on the diagnosis and treatment of bipolar disorder in children, but indicated that only one sentence in *DSM-IV* refers to this disorder in children, since the latest edition appeared before much of the recent research was presented. The *DSM* "should reflect the current understanding of this disorder," the paper states.

• **continue to support federal legislation to establish an open clinical-trials registry for new medications** that would include studies whose findings were negative as well as positive. The Assembly also urged APA to promote awareness of such a registry, should it be established, at all of its scientific meetings and continuing medical education sessions and to publish both negative and positive study findings in APA journals.

• **urge APA to work to terminate Medicaid's Institution for Mental Diseases (IMD) exclusion, which bars hospitals, nursing facilities, and other institutions from eligibility to receive Medicaid reimbursement if they have more than 16 beds.** When Congress approved this exclusion when Medicaid was enacted in 1965, it signaled the federal government's intention to leave the burden of paying for long-term psychiatric care in these facilities with the states. The exclusion applies to indigent adults aged 21 to 65. Ending this exclusion should provide psychiatric patients with "their fair share of health care dollars," said Jeffrey Geller, M.D., one of the paper's authors. Concern was expressed, however, over the possibility that eliminating the exclusion could threaten a funding source for general hospitals that treat psychiatric inpatients and have 16 or fewer beds. Others maintained that this could halt a nationwide closure of psychiatric beds because more facilities would be eligible for reimbursement through Medicaid, thus increasing access to the mental health care system.

• **amend APA's position statement on same-sex unions** to add a phrase indicating that APA not only "supports the legal recognition of same-sex unions and their associated legal rights, benefits, and responsibilities" but also "opposes restrictions to those same rights, benefits, and responsibilities."

• **add additional incentives for psychiatry residency programs to get all of their trainees to join APA and thus qualify for the 100% Club.** It wants the Board of Trustees to change the $100 annual contribution the program receives toward buying APPI books to one that provides programs with "one major APPI textbook for each year the program qualifies" for the 100% Club. These programs would also receive a free online subscription to the APA continuing medical education journal *Focus*.

• **approve minor technical revisions to several APA position statements related to HIV/AIDS,** including those on confidentiality in outpatient psychiatric services, HIV in adolescents, and HIV infection in pregnant women. The changes were to add updated statistical data, clinical information, current treatment protocols, or text references.

• **endorse a new position statement on the psychiatric implications of comorbid HIV and hepatitis C infections.** The statement was developed by the Committee on AIDS to respond to the mental health implications of the growing public health problem posed by this type of coinfection and its treatment. About 25 percent of HIV-infected Americans have comorbid hepatitis C infection. The statement describes the dimensions of the neuropsychiatric aspects of the problem and of its treatment. Among the statement's recommendations are that patients be treated for mood disorders prior to initiating treatment for hepatitis C and that psychiatrists should closely monitor changes in neuropsychiatric functioning in patients with this coinfection. This monitoring includes drug-drug interactions and interactions of antiretroviral treatments with substances of abuse.

• **ask the Board of Trustees to decide whether APA should meet with the New York Academy of Medicine to discuss joining its group Doctors Against Handgun Injury.** This is a coalition of a dozen national medical societies whose mission is to "enhance awareness of the link between handguns and suicide and to increase clinical and public health programs" focused on this issue. The paper noted that since mental health issues are intimately bound up in suicide decisions, APA has considerable expertise to contribute in this area.

• **encourage the medical director and Board of Trustees to continue their lobbying efforts to have the Virginia legislature change a state law prohibiting employers from offering health insurance to the domestic partners of their employees.** Virginia is the only state to have codified such a ban. The issue became critical to APA when it moved its headquarters from Washington, D.C., to Arlington, Va., in late 2002. At that time APA learned that it was no longer permitted to offer the benefit, which had been available to staff for more than a decade.

A summary of the Assembly's actions is posted in the "Members Corner" section of APA's Web site at <www.psych.org/members/gov/assembly/maynovmtg/nov04final.cfm>. ■

Applicants Sought for Minority Medical Student Scholarship

APA invites applicants for its 2005 Annual Meeting Travel Scholarship for minority medical students. This scholarship is for medical students who have an interest in psychiatric issues in medicine and provides experiences to foster that interest.

The scholarship supports travel and related costs for medical students to attend APA's 2005 annual meeting, which will be held May 21 to 26 in Atlanta. In addition to attending scientific sessions, students will participate in enrichment fellowship activities and be assigned a mentor.

This scholarship is part of the APA Minority Fellowships Program and is supported by the Substance Abuse and Mental Health Services Administration and AstraZeneca. It is open to currently enrolled U.S. minority medical students. Selected students who are not APA members will automatically receive membership.

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

Applications are due February 28, 2005.

Applications and more information are available by contacting Marilyn King by phone at (703) 907-8653 or by e-mail at mking@psych.org. An application form is posted on APA's Web site at <www.psych.org/med_ed/MedStudTravApp04.pdf.>. Additional information is posted at <www.psych.org/med_ed/cmhs_index.cfm>. ■

Fellows Selected for APA's Minority Fellowships Program

APA has announced the names of 31 minority psychiatry residents selected to participate in the APA Minority Fellowships Program as either an APA/SAMHSA or an APA/AstraZeneca fellow. This is the largest combined group of fellows ever selected.

2004-2005 APA/SAMHSA Minority Fellows

Davin Agustines, M..D., Harbor-UCLA Medical Center
Jon Boone, M.D., University of California, San Francisco
Toya Clay, M.D., Columbia University/New York-Presbyterian Hospital
Allison V. Downer, M.D., Albert Einstein College of Medicine
Abiodun Famakinwa, M.D., Howard University
Aliya Carmichael Jones, M.D., University of Maryland/Sheppard Pratt
Niranjan Karnik, M.D., Stanford University
Sabina Lim, M.D., Yale University
Ronald Means, M.D., University of Maryland/Sheppard Pratt
Cynthia Resendez, M.D., UCSF-Langley Porter
Yanni Rho, M.D., Massachusetts General Hospital/McLean Hospital
Lauren Shin, M.D., University of Chicago
Sherri Simpson, M.D., Baylor College of Medicine
Nhi-Ha Trinh, M.D., Massachusetts General Hospital/McLean Hospital

Two residents at New York University Medical Center have been chosen as APA/SAMHSA Substance Abuse Fellows. They are Deborah Cano, M.D., and Militza Mizray, M.D.

2004-2006 APA/AstraZeneca Fellows

Seeba Anam, M.D., New York University
Angel Caraballo, M.D., State University of New York at Stony Brook
Yolonda Colemon, M.D., Michigan State University
Luisa S. Gonzalez, M.D., Columbia University at Harlem Hospital Center
Hamada Hamid, M.D., New York University
Moddy Kiluvia, M.D., Cabrini Medical Center, New York City
Gonzalo Laje, M.D., National Institute of Mental Health and Children's National Medical Center
James E. Lee Jr., M.D., University of South Carolina School of Medicine/Palmetto Health Alliance
Jennifer Robin Lee, M.D., Harvard Longwood
Raquel Lugo, M.D., University of Connecticut
Janet A. Martin, M.D., Cedars-Sinai Medical Center, Los Angeles
Sunil Saxena, M.D., Behavioral Health Science Center, N.Y.
Nakia Gray Scott, M.D., Scott and White Memorial Hospital/Texas A&M Medical School
LaShondra T. Washington, M.D., Tulane University
O.C. White III, M.D., King/Drew University ■

ANNUAL MEETING DIRECTOR MARKS SILVER ANNIVERSARY AT APA

APA Medical Director **James H. Scully Jr., M.D.,** presents **Cathy Nash,** director of APA's Annual Meetings Department, with a plaque at a surprise luncheon in late October in recognition of Nash's 25 years of service to APA. The luncheon was planned by Scully, a former director of APA's Division of Education and Career Development, and Deborah Hales, M.D., the current director.

Nash, who has overseen APA's annual meeting since 1984, began working at APA as a secretary and was quickly promoted to CME course coordinator. Over the years, Nash, now director of APA's Annual Meetings Department, helped turn APA's annual meeting into one of the largest and best medical specialty meetings in the world, according to Hales. The 2004 annual meeting, which was held last May in New York City, had a record attendance of nearly 27,000.

At the luncheon, Scully commended Nash not only for her years of service, but for her drive, determination, and dedication to APA.

Free Subscription

U.S. and Canadian members of APA can receive a free subscription to *Psychiatric Services* as a benefit of membership. To subscribe, go to the Web site <www.psych.org/ps> and access the "request for subscription" form. After printing out and completing the form, fax or mail it as instructed. Your free subscription will begin in six to eight weeks. International members have free online-only access to the journal. To activate your online subscription, go to <http://ps.psychiatry online.org> and follow the instructions.

Chronic Illness a Prescription For Financial Distress

Insurance does not save Americans with chronic illness from harsh financial burdens.

BY KATE MULLIGAN

Rising health care costs have hit particularly hard low-income, privately insured people who suffer from chronic illness, according to a report from the Center for Studying Health System Change (HSC) by Ha T. Tu.

Between 2001 and 2003, the proportion of low-income, chronically ill people with private insurance who spent more than 5 percent of their income on out-of-pocket health care costs grew from 28 percent to 42 percent. Low income was defined as family income below 200 percent of the federal poverty level, or $36,800 for a family of four in 2003.

A majority (68 percent) of the chronically ill working-age adults who reported high health care costs and access problems are covered by private insurance.

Overall, in 2003, more than 1 in 5, or 12.3 million, people with chronic conditions lived in families with problems paying medical bills. Chronic conditions, as defined by HSC, include depression and nine other conditions such as asthma, diabetes, and heart disease.

The financial burden is even more difficult for uninsured Americans with chronic illness. Forty-five percent of uninsured Americans with chronic conditions reported problems paying medical bills.

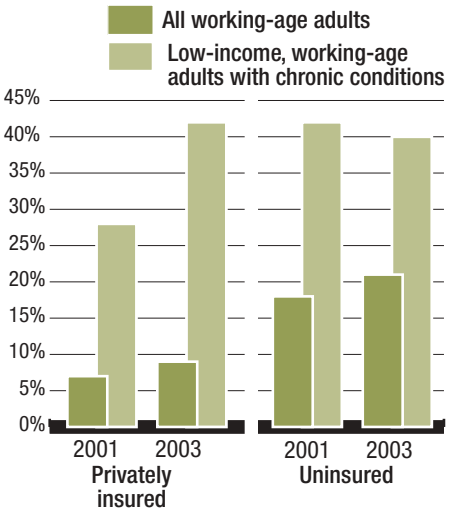
Not surprisingly, both insured and uninsured Americans with problems paying medical bills suffered from other financial consequences. Sixty-eight percent of families with problems paying medical bills because of chronic illness also reported problems paying for necessities such as food and shelter.

The HSC estimated that 57.3 million working-age Americans—33 percent of the working age population—have at least one chronic condition.

"Rising Health Costs, Medical Debt, and Chronic Conditions" is posted online at <www.hschange.org/CONTENT/706/>. ■

Medical Bill Burden

Having health insurance does not financially protect chronically sick, low-income people. Below is a comparison of individuals who spend more than 5% of their income on out-of-pocket medical costs.



Source: Center for Studying Health System Change, 2004

Program Information for New York Psychiatrists

Q. I am moving to New York and have discovered that my current malpractice insurance carrier does not offer coverage there. Is the Psychiatrists' Program, the APA-endorsed Psychiatrists' Professional Liability Insurance Program, available in New York? If so, how do I apply for coverage?

A. Coverage through the Program is available in all 50 states plus the District of Columbia. Nationwide coverage is just one of the many benefits of participation in the Program. For more information, refer to the end of this column on how to contact PRMS.

By the way, if you decide to make another move in the near future, as a Program participant you will not have to transfer between insurance companies again as coverage through the Program is portable. If you are currently a participant in the Program and you are changing locations, call your underwriter at (800) 245-3333 prior to your move to update your policy (requirements may vary by state).

Q. I currently participate in the New York Medical Malpractice Insurance Program (the Excess Program). Will The Psychiatrists' Program be offering seminars to fulfill the risk management education requirement?

A. Yes, PRMS is planning to provide participants with complimentary risk management courses necessary to meet the regulatory course requirements for policy year 2004-05 for physicians participating in the Excess Program. Additionally, attending one of the seminars or taking the online risk management course will qualify you for the 5 percent premium credit in accordance with the New York State Department of Insurance regulations.

For those who don't live in New York, the Excess Program was established by the state of New York to provide certain physicians in the state with an additional layer of medical malpractice insurance coverage above the policy limits provided by primary malpractice coverage. Neither PRMS nor the primary medical malpractice company is directly involved with the Excess Program. However, PRMS, on behalf of the primary company, is required to offer a risk management program to those insureds who participate in the Excess Medical Malpractice Insurance Program, pursuant to New York Insurance Regulation 124, as amended.

Under New York State Insurance Regulation 124, physicians who participate in the New York Medical Malpractice Insurance Program (the Excess Program) must fulfill the following risk management education requirements in order to remain eligible for the Excess Program: a five-hour basic risk management course accompanied by a project that must be completed within 60 days of the course and an annual three-hour follow-up risk management course accompanied by a project that must be completed within 60 days. Here is the schedule of the next round of seminars:

- January 27, 2005, New York City
- February 11, 2005, New York City
- February 12, 2005, White Plains, N.Y.
- Online courses will be available in late fall; check <www.psychprogram.com>

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

Minority Fellowships Program Invites Applicants

Psychiatry residents are invited to apply for APA's Minority Fellowships Program. The program provides educational enrichment to psychiatry trainees and stimulates their interest in providing high-quality services to minorities and the underserved. It is also designed to involve the fellows in psychiatry in APA's work and to give APA the perspective of young psychiatrists.

There are three groups of fellows under the Minority Fellowships Program: APA/SAMHSA Fellows (funded by the Substance Abuse and Mental Health Services Administration), APA/SAMHSA Substance Abuse fellows (funded by the Centers for Substance Abuse Treatment and Substance Abuse Prevention), and APA/AstraZeneca Fellows (funded by AstraZeneca).

The SAMHSA and substance abuse fellows receive a government stipend for 12 months (based on their PGY level). AstraZeneca fellows do not receive stipends and serve for two years. Residents must be APA members, U.S. citizens, and in at least PGY-2 by July 2005 to apply or PGY-5 for the substance abuse segment. Residents interested in the substance abuse segment must be in a substance abuse training program approved by the affiliated medical school or agency in which a significant number of substance abuse patients are from minority and underserved groups.

The deadline for applications is January 31, 2005. More information is available by contacting Marilyn King by phone at (703) 907-8653 or by e-mail at mking@psych.org. Information is also posted online at <www.psych.org/med_ed/cmhs_index.cfm>. ■

Bullying's Sequelae Know No Borders

Throughout the world, bullying seems to impact negatively the mental and physical health of victims. But bullies have problems too.

BY JOAN AREHART-TREICHEL

Cruelty and power plays—better known as bullying—are problems for youth throughout the world, a new study reveals.

The study was headed by Tonja Nansel, Ph.D., an investigator at the National Institute of Child Health and Human Development in Bethesda, Md. Results appeared in the August *Archives of Pediatrics and Adolescent Medicine*.

Involvement in bullying at school—as bully, victim, or both—varies dramatically across countries, from as low as 9 percent of youth in Sweden to 54 percent of youth in Lithuania, with an average across countries of 11 percent of youth. (Some 25 percent of young people in the United States are involved.) But the consistency of findings regarding the link between bullying and poor psychosocial adjustment and poor health is striking.

Specifically, youths involved in bullying—as bully, victim, or both—reported significantly poorer emotional and school adjustment and significantly higher levels of health problems than did noninvolved youth in nearly all the countries surveyed. Health problems included headaches, stomachaches, backaches, irritability, nervousness, sleeping difficulties, and dizziness. Further, victims of bullying reported significantly more problems in relationships with classmates than did noninvolved youth in all 25 countries surveyed, and bullies reported significantly more problems in relationships with classmates than did noninvolved youth in 15 out of the 25 countries surveyed.

Thus, being a victim of bullying seems to have an adverse effect on youths' psychological and social development and health regardless of the country in which they live. But so does being a perpetrator of bullying.

'Bully-Victims' Worst Off

In fact, youth who are both bullies and victims of bullying—so-called "bully-victims"—may experience the worst physical and mental health consequences of all, the study revealed. Bully-victims reported levels of emotional adjustment, relationships with classmates, and health problems similar to those of bullying victims and levels of school adjustment and alcohol use similar to those of bullies. What's more, in some cases, their school adjustment and health scores were significantly worse than those of either bullies or victims.

The researchers offered some possible explanations for this finding. For example, being bullied may lead to poor emotional adjustment by negatively shaping a youngster's self-image; this explanation is supported by other studies conducted in several countries. The stress of being bullied may lead to health problems, although only a few studies have examined the relationship between bullying and health. For both bullies and victims, problematic peer relationships may interfere with learning. And bullies may experience further school-related troubles because they often use alcohol. In this study, bullies were found to use more alcohol than noninvolved youth in all of the 25 countries surveyed.

All in all, Nansel and her colleagues concluded in their study report, "Bullying is a critical issue for the health of youth internationally. . . . Bullying is not only a problem that influences individuals; it transcends peer groups, communities, and countries and as such is a significant international public health issue that warrants attention."

Indeed, research published during the past 15 years has shown that bullying is prevalent across countries. However, studies have varied regarding their definitions of bullying and measurements of bullying. So "this is the first study, to our knowledge, assessing the relationship between bullying and psychosocial adjustment across countries in nationally representative samples by standard measures and methods," Nansel and her team pointed out in their report.

> **"Bullying. . . transcends peer groups, communities, and countries, and as such is a significant international public health issue."**

The data they used for their study came from a 1997-98 international investigation called the Health Behavior in School-Aged Children Study, performed in collaboration with the World Health Organization. During this investigation, information about youth's health-related behaviors, including bullying, was gathered from some 113,000 students between the ages of 12 and 16 years in 25 countries during the 1997-98 academic year.

AMA Findings Reinforced

"These results reinforce the findings of the American Medical Association's Council on Scientific Affairs on the importance of prevention and early intervention in limiting bullying behaviors in school children," Carolyn Robinowitz, M.D., said in an interview. Robinowitz is a member of the AMA's Council on Scientific Affairs and a coauthor of a landmark AMA report on bullying (*Psychiatric News*, August 2, 2002).

"I noted that Sweden, which has adopted comprehensive programs to address bullying in school, had the lowest reported bullying," she added. "This certainly suggests that programs work and is a message for us in this country to employ more resources in the prevention of bullying and in the treatment of bullies and their victims."

The finding that the prevalence of bullying varies considerably from country to country is "very interesting and suggests that social and cultural factors are very important," Lois Flaherty, M.D., chair of the APA Council on Children, Adolescents, and Their Families, told *Psychiatric News*.

please see ***Bullying*** *on page 44*

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

MCOs Try New Ploy: Demanding Fee Discounts

There's a new twist for out-of-network psychiatrists who care for patients enrolled in managed care organizations (MCOs). In the past few months, APA's Managed Care Help Line received information from three members who were asked to discount fees for patients they saw out of network. Generally, when something new is afoot in the managed care world, it doesn't take long for the Help Line to hear about it.

A number of managed care organizations contract with other companies to contact providers and entice them into accepting discounted fees for the services they provide to the MCO members. The discounts requested of the three callers ranged from 20 percent to 30 percent.

One of the callers, an APA member from Wisconsin, received a notice from a company based in Florida, ASMED Health Partnership. This company sought to remit 80 percent of the "qualifying expenses less the employee copay/coinsurance to be remitted no later than 12-14 days after approval." Recipients were informed in lettering they couldn't miss, "THIS AGREEMENT IS IN LIEU OF AN AUDIT." This statement implies that physicians who do not agree to the 20 percent discount may have their billings audited, or, conversely, those who agree to the discount will not be audited.

Moreover, the notice, and the other ones reported to the Help Line, demanded an immediate response. "Please respond on or before 2:00 Eastern Standard Time," reads the ASMED letter. "IMMEDIATE RESPONSE REQUIRED."

Ellen Jaffe of APA's Office of Healthcare Systems and Financing called ASMED and asked why the company demanded an immediate response. While she failed to get an adequate answer to that question, she did learn that ASMED sometimes works on a bounty system and receives a percentage of the money it saves the MCO.

The other two callers were psychiatrists in New York City who saw patients covered by UnitedHealthCare (UHC). UHC has apparently contracted with MultiPlan, an organization that has its corporate headquarters in New York, to get out-of-network providers to agree to discounted fees. A press release on the MultiPlan Web site explains how new software allows third-party payers to "submit out-of-network claims directly to the MultiPlan Network for an additional opportunity to save on medical costs. Clients pay for access on a percentage of savings basis."

MultiPlan tells physicians that UHC has asked the company to do a "bill process review" involving "evaluation for compliance with recognized standards for reasonable and customary (R&C) pricing, coding, and utilization. . . . In consideration of accelerated processing, prompt payment, and reduction of patient liability on this claim, we are asking that [provider named here] (Provider) agree to accept the adjusted price listed below as the full payment for services rendered on the following dates."

One notice sent to the Help Line requested that a $1,000 bill be discounted to $700; the other demanded a reduction from $675 to $499.50.

Brian T. Lipton, M.D., a New York psychiatrist who has received several requests for discounted fees from MultiPlan, was incensed. "There is so much wrong with this latest ploy from insurers. It is an intrusion on the physician-patient relationship and is done without the knowledge or permission of the patient, and it's a form of blackmail. The insurer implies that the patient's claim will not be paid in a timely fashion unless the physician agrees to a discount. It's just unethical."

Karen Sanders, the director of APA's Managed Care Help Line, advises APA members that they have no obligation to comply with requests for fee reductions. The out-of-network physician's relationship is solely with the patient, not with the MCO. The patient agrees to the physician's standard fee with the understanding that the MCO will pay according to what is delineated in the patient's insurance contract. Thus, the issue is really between the patient and the MCO, since the patient has probably already paid the out-of-network physician. Nonetheless, a physician's refusal to discount fees could carry an insidious price: it could undermine the patient-doctor relationship if the patient is not reimbursed in a timely manner—or at all.

If you've received requests for discounts for out-of-network care you've provided to patients, please contact the Managed Care Help Line by phone at (800) 343-4671 or by e-mail to hsf@psych.org. ■

Psychiatric Practice & Managed Care *(PP&MC)* and *Psychiatric News* will continue updating APA members on practice management issues via the pages of *Psychiatric News.* This abbreviated version of *PP&MC* is printed bimonthly in *Psychiatric News* and coincides with the posting of each new issue of *PP&MC* on APA's Web site. To access the newsletter, go to <www.psych.org>, click on "Members Corner," and scroll down to "Newsletters."

Contract Alert

It goes without saying that you should read any contract carefully before you sign it. One item you need to look for on contracts with managed care organizations (MCOs) is a limitation on the procedural codes (CPT codes) for which they are willing to pay you. APA's Managed Care Help Line has learned that some MCO contracts limit the CPT codes for which they will reimburse psychiatrists to the psychiatric codes only (the 908xx series of CPT codes). As a psychiatrist, of course, you are entitled to use any CPT code that accurately describes the care you provide, including evaluation and management services denoted by the 99xxx series of CPT codes. However, if you have signed a contract limiting you to the use of psychiatric codes only, you will not be paid for anything else. If you have any questions about this limitation, please call the Managed Care Help Line at (800) 343-4671.

Opt-Out Clarification

On a regular basis, APA's Managed Care Help Line receives calls from psychiatrists thinking about opting out of Medicare so that they can see Medicare patients under private contracts. The information about opting out and the forms for completing an opt-out application and creating private contracts with Medicare patients are posted on APA's Web site at <www.psych.org/members/practpsych/optingoutofmedicare112701.cfm>.

Psychiatrists sometimes run into a problem with opting out because although they don't wish to see Medicare patients in their private practices, they may work at clinics where they provide care to Medicare patients as part of their employment. It is important to understand that even though the clinic may bill under its own number to Medicare and does not use the physician's UPIN, legally Medicare does not pay for treatment provided by a doctor who has opted out of the program. This is the official word that APA's Office of Healthcare Systems and Financing received from Fred Grabau, a health insurance specialist in the Centers for Medicare and Medicaid Services' Division of Technical Payment Policy. If you hear otherwise from colleagues, or even from your Medicare carrier, what you hear is incorrect.

If you have opted out of Medicare and want to continue your clinic work, you must make it clear to the clinic that you can see Medicare patients only under private contracts and that the patients will not be able to receive any reimbursement from Medicare.

For questions about opting out or Medicare in general, call APA's Help Line at (800) 357-7924. ■

CPT Q&A

Q: ***How do I choose between using a psychotherapy code with E/M or 90862, the pharmacologic management code?***

A: You need to consider the primary service you provided. If you saw the patient for medication management and provided no or minimal psychotherapy, choose 90862. If, however, you primarily had a psychotherapy session during which you evaluated the patient's medication regimen, choose the psychotherapy code with E/M that appropriately describes the length of time of the session.

If you have a specific CPT coding question, you can e-mail your query to hsf@psych.org, and we'll forward it to APA's CPT coding experts and provide you with an answer. ■

Quick Facts

The health insurance gap among Latino, black, and white Americans persisted in 2003, with 1 in 3 Latinos, 1 in 5 blacks, and 1 in 10 whites under age 65 lacking health insurance. —National Survey released October 28, 2004, Center for Studying Health System Change

Of the $1.6 trillion spent on health care in 2002, physicians and clinical services accounted for 22%, hospital care accounted for 31%, prescription drugs for 11%, and long-term care for 36%. —T. Albert in *American Medical News,* August 9, 2004

Adults with a substance use disorder were almost three times as likely to have serious mental illness (20%) as those who did not have a substance use disorder (7%). —*Mental Health Weekly,* August 2, 2004

Psychiatric claims make up 7% of MetLife's group short-term disability claims, but the percentage is nearly twice as high for white-collar employees. —"A Year in the Life of a Million American Workers," MetLife, 2003

Five medical conditions—heart disease, trauma, pulmonary conditions, cancer, and mental disorders—are responsible for nearly one-third of the $314 billion increase in health care spending in the United States between 1987 and 2000. —K.E. Thorpe et al. in *Health Affairs,* August 25, 2004

Psychiatrist Explores World Beyond 'Normal'

Forty years ago, psychiatrist Ian Stevenson, M.D., started researching the paranormal. Some psychiatrists thought he had become "unhinged." Others, however, were intrigued by his efforts.

BY JOAN AREHART-TREICHEL

During the past 40 years, a University of Virginia psychiatrist named Ian Stevenson, M.D., has traveled around the world to study cases that are possibly paranormal—that is, phenomena that cannot be explained by natural processes and are not the result of deception.

Even today, at age 85, the tall, slender, and dignified Stevenson is pursuing this, his passion. In fact, he and his colleagues at the University of Virginia's Division of Personality Studies constitute one of the few paranormal investigative teams in the world.

Ian Stevenson, M.D.: "My research has deepened my convictions about the possibility of life after death."

Stevenson was born in Montreal, Canada. He attended McGill University medical school and graduated in 1943. His interest in internal medicine during his medical studies led him to an interest in psychosomatic medicine, which then prompted him to become a psychiatrist. While in training as a psychiatrist, he started reading journals concerning paranormal research.

"I thought, this is important, and not many people are doing it," Stevenson said during an interview in his office, which is located in a circa 1920 house on the edge of the University of Virginia grounds.

In 1957 the dean of the University of Virginia School of Medicine interviewed Stevenson for the position of chair of psychiatry there. "I was frank with the dean," said Stevenson. "I told him that I was interested in paranormal phenomena." The dean was not deterred by this interest, and Stevenson was offered the position.

In 1960 Stevenson wrote a paper about claims of memories of previous lives. Chester Carlson, the inventor of the Xerox process, and his wife, who believed in reincarnation, read the paper and offered to fund some of Stevenson's paranormal research. Then, in 1967, Carlson died and bequeathed $1 million to the University of Virginia so that Stevenson could continue his paranormal research.

Stevenson relinquished his position as chair of psychiatry and used the money from Carlson to establish the Division of Parapsychology in the University of Virginia's department of psychiatry. (Later this division was renamed the Division of Personality Studies.) Now Stevenson could not only pursue paranormal research full time, but also hire colleagues to assist him.

Cases Said to Be Authentic

Out of the some 3,000 possibly paranormal cases that he and his coworkers have researched over the years, only several hundred cases appear to be strong in evidence, Stevenson pointed out. But these several hundred cases, he said, are indeed intriguing. He then described a few of them.

Back in the 1970s, for example, while under the influence of hypnosis, the wife of an Elkton, Va., minister—Delores Jay—assumed the personality of a latter 19th century German named Gretchen Gottlieb. Jay spoke fluent German whenever she assumed the Gretchen personality, although she had apparently never learned German nor had had any contact with someone who spoke it.

"I think most memories of previous lives recalled under hypnosis are fantasies," Stevenson said. "But this appears to be an exception because the subject was able to speak a foreign language that she had apparently not learned normally."

A Lebanese boy was convinced that he was a man who had died in a village at some distance from his own. The boy and his family had purportedly never met the deceased and his family.

Stevenson took the boy to the village where the dead man had lived, introduced the boy to relatives of the man, and told them that the boy thought that he was a reincarnation of the man. The relatives asked the boy where, in his previous life, he had kept his dog. The boy pointed to the right place. The relatives asked the boy what his sister in his previous life was called. He gave the correct name. The relatives asked him where, in his previous life, he had lain while dying from tuberculosis. He pointed to the correct location. And when the relatives asked him where, in his previous life, he had kept his gun hidden, he pointed to the right spot.

"The child knew details about the deceased man and his family that I'm sure he could not have learned normally," Stevenson said. "Such cases are quite rare. We have only about 35 cases of that quality."

A woman who had just given birth developed a blood clot in her lungs. She became aware that she was looking down on her own body. She heard the nurses telling the doctor that she had died, as well as other parts of their conversation. Later, after she was revived, she told the nurses and doctor what she had heard. They confirmed that it was correct.

A mediumistic séance was held in Iceland. A dead person appeared to communicate with the medium. The deceased asked those present to look for a human leg in the house of one of the persons present. They did as bid, and indeed, they found a human femur wedged between the walls of the house. The femur, it turned out, belonged to a man who had drowned near the house.

Rewards Are Plentiful

Exploring and documenting such cases give Stevenson a deep sense of fulfillment. "It has been a pleasure working on the frontiers of knowledge," he said.

He enjoys sharing his discoveries with members of the Society for Scientific Exploration. These are scientists who are well established in their fields, say, in physics or astronomy, but who are also looking into various types of scientific anomalies or possibilities, such as UFOs or life in other solar systems.

Stevenson is grateful to Carlson for the bequest, which allows him to pursue such research. "Also, knowing Chester personally was such an enrichment in my life," Stevenson recalled. "He was a splendid person—amazingly modest, yet penetrating in his judgments."

Stevenson likes the publicity that he and his research have garnered in recent years. "The *London Daily Telegraph* wrote about me a few months ago," he said. "A reporter from the *Washington Post* traveled with me to India and wrote a book about my research, *Old Souls: The Scientific Evidence for Past Lives*. I get one or two letters a week from the public. Most of the letters I receive are favorable."

Drawbacks Come With Territory

Nonetheless, paranormal research has its detractions, Stevenson admitted.

In the 1960s the president of the University of Virginia received mail from alumni protesting the establishment of a division of parapsychology at the university. "My wife was very distressed," Stevenson recalled. "She said, 'You're ruining a promising career. Why do you want to do this?' "

Most of Stevenson's paranormal findings have been published in specialty journals such as the *Journal for Scientific Exploration* and *Journal of the American Society for Psychical Research*, although some have been published in more widely read publications such as the *American Journal of Psychiatry* and *Journal of Nervous and Mental Disease*. Stevenson would now like to see some of his discoveries published in periodicals such as the *Journal of the American Medical Association*. Yet given the unconventionality of his research, achieving that goal is difficult, he said.

To date, the only researchers who have verified Stevenson's findings about children who remember past lives are people he has funded himself via the Department of Personality Studies. He would also like to see some of his findings confirmed by independent scientists.

Regarding his reputation in the psychiatric community, "Not a few psychiatrists suspected that I had become unhinged," Stevenson avowed.

Colleagues Praise Work

Still, not a few psychiatrists seem to be intrigued by his research. Some also have good words for it.

"I have read some of Ian Stevenson's work and am impressed by his persistent and patient-data gathering although I don't agree with his interpretations," Eugene Brody, M.D., told *Psychiatric News*. Brody is affiliated with Sheppard Pratt Hospital in Baltimore and editor in chief of the *Journal of Nervous and Mental Disease*.

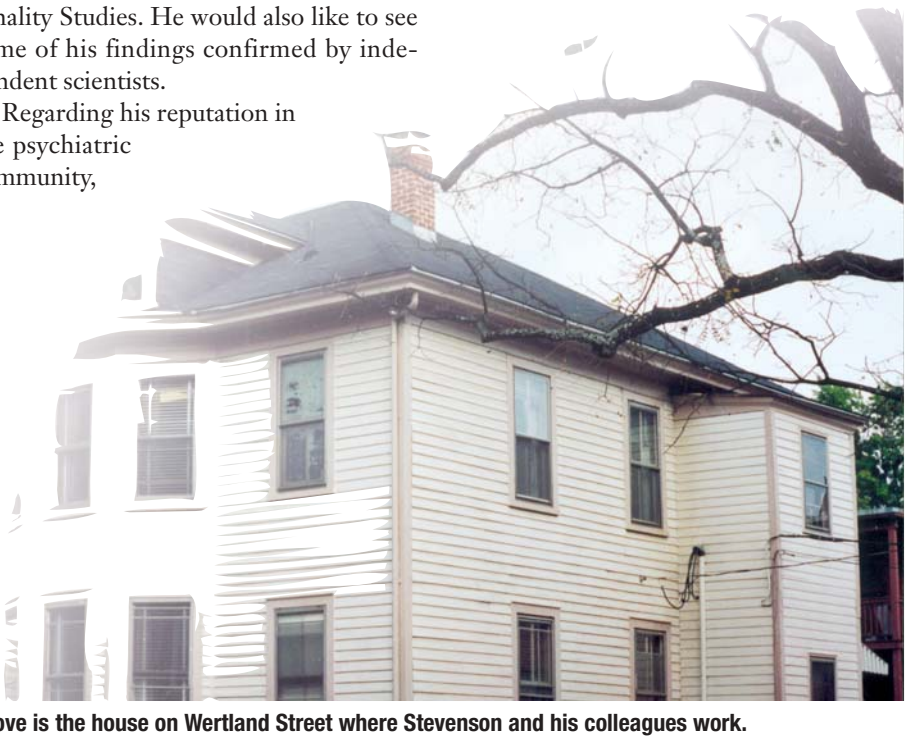
"Dr. Stevenson is a careful, meticulous researcher and scholar," Harold Lief, M.D., emeritus professor of psychiatry at the University of Pennsylvania, said in an interview. "That makes his findings even more intriguing than if he were a rogue or charlatan. . . .He is positively obsessive in the way he goes about collecting data."

"His case histories concerning memories of previous lives are detailed and involve multiple informants," Paul Wender, M.D., a distinguished professor of psychiatry emeritus at the University of Utah, added. "The data for most are subject to critique because Dr. Stevenson usually contacts cases that have been reported in the past, and the accuracy of the reports is therefore dependent on the reliability of his informants' memories. Recently he has collected a series of cases in which children have made claims about a past life, and these claims have been recorded prior to the child's contact with his putative previous family. The family is subsequently contacted, and the accuracy of the child's claims determined. Many of these children's memories of another life are reported to have been correct. The accuracy of these reports is not dependent on the accuracy of informants' memories and avoids the critique I mentioned above."

Yet assuming that some of Stevenson's cases are authentic—that they cannot be explained either by natural processes or by deception—then what is the explanation for them? Brody, Lief, and Wender concurred that that is the critical question. So does Stevenson.

"My research," he said, "has deepened my convictions about the possibility of life after death."

More information on Stevenson's paranormal research is posted online at <www.healthsystem.virginia.edu/personalitystudies>. ■



Above is the house on Wertland Street where Stevenson and his colleagues work.

Depressed Patients Do Better When They Get RESPECT

Physicians using a manualized depression-treatment program were more thorough in evaluating suicide risk, more likely to hand patients educational material about depression, and more apt to promote patient self-management.

BY MARK MORAN

A manualized program for treating depression in primary care settings that emphasizes collaboration between psychiatrists and primary care physicians—as well as telephone case management—appears to offer significant improvement in patient outcome over standard care.

In a randomized clinical trial involving three large medical group practices, two health plans, and more than 400 patients, the manualized program, called "Re-Engineering Systems for the Primary Care Treatment of Depression" (RESPECT-Depression), was found to significantly improve response to treatment, rates of remission, and satisfaction with care.

A report on the trial appears in the September *British Medical Journal (BMJ)*.

Developed by the MacArthur Initiative on Depression and Primary Care, RESPECT-Depression integrates work by primary care clinicians who manage patients, centralized care managers who provide telephone support, and psychiatrists who supervise the care managers and offer suggestions to clinicians about treatment and management.

At each practice, clinicians and staff are trained using materials developed by RESPECT-Depression researchers and customized to each setting by the organizations.

The MacArthur Initiative is making the RESPECT-Depression materials available at no cost to medical practices that want to adopt it. Those materials can be downloaded from the Web at <www.depression-primarycare.org/clinicians/re_engineering/>.

The essential components include training primary care clinicians in the use of the RESPECT-Depression materials, telephone care management, and closer relationships between mental health and primary care clinicians, said Allen Dietrich, M.D., a professor of community and family medicine at Dartmouth Medical School and co-chair of the MacArthur Initiative.

"Professionals work together through these three components and provide more systematic patient education, promotion of patient self-management, and monitoring of suicide risk. Especially important is supporting modification of the management plan if the patient's symptoms are not improving."

Follow-up Much More Likely

In the study, 405 patients with depression were randomly assigned to treatment using the RESPECT-Depression model or standard care. At six months, 60 percent of 177 patients receiving the intervention had responded to treatment compared with 47 percent of 146 patients in usual-care practices. At six months, 37 percent of the intervention patients showed remission compared with 27 percent of the usual-care patients.

Ninety percent of the intervention patients rated their depression care as good or excellent at six months compared with 75 percent of usual-care patients.

The organizations participating in the clinical trial were Intermountain Health Care in Salt Lake City, Colorado Access in Denver, Highmark Blue Cross Blue Shield in Pittsburgh, and ProHealth Physicians Group in Bloomfield, Conn. The evaluation center was led by Herbert C. Schulberg, Ph.D., and was based at Cornell University.

Dietrich said physicians using the intervention were found by independent evaluators to be more thorough about evaluating suicide risk, more likely to hand patients educational material about depression, and more likely to promote self-management on behalf of the patient.

"It's also true that the RESPECT patients were much more likely to get a series of follow-up contacts from the clinician," Dietrich said. "They had both more follow-up visits over the three months following the index visit—following the first visit. And they were also much, much more likely to get a telephone support call."

Treating Returning Soldiers

The military is also interested in adopting the model for treatment of soldiers returning from overseas.

In a teleconference press briefing about the *BMJ* report, Charles C. Engel, M.D., director of the Defense Department's Deployment Health Clinical Center at Walter Reed Army Medical Center in Washington, D.C., said the center is working with the RESPECT-Depression team to develop a modified model of the approach that will help meet the post-war primary care needs of returning soldiers and their families.

"The RESPECT model could improve early access to needed services, improve the effectiveness of those services, and reduce stigma by locating the care in a primary care setting," said Engel.

APA's Darrel Regier, M.D., M.P.H., who also participated in the teleconference, called RESPECT an "excellent" model that can be integrated into similar programs for

please see ***RESPECT*** *on page 44*

Inhaling Insulin May Improve Memory of Alzheimer's Patients

Sniffing insulin may benefit the memory of both healthy individuals and those with Alzheimer's disease. Also, a drug for treating insulin resistance may halt memory loss in Alzheimer's patients.

BY JOAN AREHART-TREICHEL

Could daily sniffs of insulin boost your memory? Even more crucial, could they improve the memories of Alzheimer's patients? Preliminary, yet building, evidence suggests so.

A small study in the November *Psychoneuroendocrinology* found that healthy young persons' memories can profit from inhaling insulin. The lead investigator was Christian Benedict, M.D., a nutrition scientist at the University of Lübeck in Germany.

In this trial, 38 healthy individuals aged 18 to 34 years sniffed either 40 I.U. of insulin four times a day during an eight-week period or saline (a placebo) four times a day during the same period. Both at the start of the study and seven weeks into it, the researchers had the subjects learn words, then try to recall them a week later. Neither group's delayed word recall was as good at the end of the study as it had been at the start—apparently because of false recall of words from previous word lists. Nonetheless, the group getting insulin performed significantly better at delayed word recall at the end of the study than did the placebo group.

"Results indicate a direct action of prolonged intranasal administration of insulin on brain functions, improving memory. . . in the absence of systemic side effects," Benedict and his colleagues concluded. "These findings could be of relevance for the treatment of patients with memory disorders like Alzheimer's disease."

Intravenous insulin was known to improve memory before Benedict and his team found that intranasal insulin can also do so, and it was that discovery that spurred Benedict and his coworkers to undertake their study. The advantage of using intranasal rather than intravenous insulin, however, is that it does not cause systemic side effects like hypoglycemia.

At the 2003 annual meeting of the Society for Neuroscience, Suzanne Craft, Ph.D., a professor of psychiatry at the University of Washington, and colleagues reported the results from a small trial indicating that insulin sniffs can boost memory in both healthy older adults and persons with Alzheimer's, but especially the latter. The study included 20 healthy older adults and 10 Alzheimer's patients. On three separate visits, the subjects received intranasal administration of saline or one of two insulin doses (20 I.U. or 40 I.U.).

Shortly after administration, subjects were tested on story recall. Both the healthy

please see ***Insulin*** *on page 25*

Internet Medical Information In Need of Good Filter

People with mental illness often turn to the Internet to seek medical information and support from others. However, the Internet is rife with misinformation, experts warn.

BY EVE BENDER

For individuals who lack social supports and feel embarrassed about their mental health problems, the Internet seems like a harmless and even friendly place to turn for help. However, there are risks involved with seeking services online, according to a panel of residents who spoke at APA's Institute of Psychiatric Services in Atlanta in October.

The three residents are 2003-05 APA/Bristol-Myers Squibb Fellows, and as part of the fellowship experience they led a workshop at the institute on the risks and benefits of Internet-based mental health forums for patients and clinicians.

About 10 percent of health "message boards," or Internet sites that allow people to post and respond to messages about a health topic, are related to mental health, according to Stephen Thielke, M.D., a PGY-4 resident at the University of Washington in Seattle.

He estimated that roughly 500,000 people a day log on to mental health–related message boards or "chat rooms," in which messages are posted and answered on an Internet site in real time.

To provide a partial picture of people who use mental health message boards, Thielke cited findings from a study by Thomas Houston, M.D., M.P.H., which examined the mental health status and treatment of a group of 103 volunteers. Houston recruited the volunteers by posting requests for participation on five "Internet support groups," or message boards and list serves for people with depression.

"The data showed that a lot of people who were using these groups overlapped with those receiving in-person care for depression," Thielke said.

Jennifer Rosenberg, M.D.: "Trying to get information on the Internet is like drinking from a fire hose, and you don't even know what the source of the water is."

Houston found that 86 percent of the volunteers met criteria for depression (as measured by a score higher than 22 on the Center for Epidemiologic Studies Depression Scale), 92 percent were receiving antidepressants, and 65 percent were receiving some form of psychotherapy.

> "It is not surprising that people use Internet forums to establish relationships and build a sense of community."

Almost 38 percent of the volunteers said they preferred online communication to in-person treatment.

Emotional support was the most commonly cited reason for using the message board, and social-support scores of volunteers were low, compared with depressed patients from another study who were not using Internet forums on depression.

People who post to the depression-related Internet forums "may be attempting to compensate for low levels of social support," Thielke suggested.

According to Jennifer Rosenberg, M.D., a clinical fellow in psychiatry at Harvard Medical School, given the isolation that can result from having a mental illness, "it is not surprising that people use Internet forums to establish relationships and build a sense of community."

Using a mental health message board or chat room may also unburden participants of the embarrassment they might experience from discussing sensitive topics with others in person.

The Internet allows those with certain mental illnesses, such as social phobia, to observe a "conversation" and take part only when they are ready, Rosenberg said.

Seeking online support for mental health problems has its benefits, such as convenience and accessibility, "It's hard for physicians to compete, since the computer is available in people's homes 24/7," she noted.

However, such usage also has its drawbacks, Rosenberg stated.

Computer users can be victimized, either through marketing scams or sexual harassment by other people using the same Internet forum to communicate.

Sometimes the boundary between self and others may be blurred, Rosenberg said, and people can become distressed after

please see ***Internet*** *on page 44*

Cognition Measurement May Help Predict Violence Risk

The executive function of violent antisocial persons does not seem to be impaired. Thus, a prefrontal cortex dysfunction is probably not a core feature of the antisocial personality.

BY JOAN AREHART-TREICHEL

The two psychiatric illnesses most implicated in violent behavior are schizophrenia and antisocial personality disorder. But how does the cognition of persons who have schizophrenia and who are violent compare with that of violent antisocial individuals?

A new study out of the United Kingdom and in press with *Schizophrenia Research* offers some tentative answers. The study was headed by Ian Barkataki, Ph.D., of the Institute of Psychiatry in London. One of the study collaborators was Pamela Taylor, M.D., a professor of forensic psychiatry at the University of Cardiff.

The study found that when certain cognitive functions in individuals with schizophrenia who have been violent are compared with the same cognitive functions in mentally healthy persons, the former are markedly worse. In contrast, the same cognitive functions in violent antisocial individuals appear to be close to those of mentally healthy persons.

Some studies have focused on either the cognitive performance of persons with schizophrenia who have been violent or on the cognitive performance of individuals with antisocial personalities, but none has compared the performance of both groups.

The study conducted by Barkataki and his group included 57 subjects—14 with a *DSM-IV* diagnosis of antisocial personality disorder and a history of violence, 13 with a *DSM-IV* diagnosis of schizophrenia and a history of violence, 15 with a *DSM-IV* diagnosis of schizophrenia without a history of violent behavior, and 15 control subjects with no previous psychiatric diagnoses and with no history of violence. All four groups were matched according to age, ethnicity, socioeconomic background, and number of years of education.

The subjects were then given a battery of tests to measure five cognitive functions: general intellectual function, executive function, attention, verbal memory, and information-processing speed.

There was no significant difference between the nonviolent and violent schizophrenia subjects on any of the measures tested except for executive function, where the violent subjects performed more poorly. Both violent and nonviolent schizophrenia subjects demonstrated significant deficits in all five domains tested compared with control subjects. Violent antisocial subjects performed as well as control subjects on all measures except information-processing speed, where they did significantly worse.

These findings have some implications for persons with antisocial personalities, the researchers believe. For instance, if the executive function of violent antisocial individuals is not impaired, then a prefrontal cortex dysfunction is probably not a core feature of the antisocial personality, as some brain metabolism studies and gray matter volume studies have suggested *(Psychiatric News,* March 3, 2000; April 5, 2002). Further, if violent antisocial persons truly process information at a sluggish rate, then the impulsive and risk-taking traits of antisocial individuals may be linked to a failure to process, in adequate time, data indicating peril. Their tardy information-processing might likewise prevent them from adequately judging social situations. For example, violent antisocial persons might fail to realize that "some remark had been made in jest," Taylor told *Psychiatric News.* "They would take it only at face value, be deeply offended, and often react aggressively."

Whether the findings have any implications for individuals with schizophrenia, however, appears less certain. Nonetheless, Paul J. Fink, M.D., a former APA president, speculates that if cognitive testing of persons with schizophrenia were to reach a level of sophistication where it could "carefully delineate those who are violent from those who are not violent," it might help combat the public's frequent, and erroneous, conviction that all persons with schizophrenia are dangerous.

The study was funded by the Community Fund, the Stanley Medical Research Institute, the Wellcome Trust, and the Zito Trust.

An abstract of the study, "A Neuropsychological Investigation Into Violence and Mental Illness," is posted online at <www.sciencedirect.com>; click "Browse A-Z of journals," then "S," then "Schizophrenia Research." ■

Antibiotic Offers Some Hope In Autism Treatment

A 5-year-old autistic boy became more sociable while he was taking D-cycloserine. The antibiotic is one of the medications that looks promising for increasing socialization in autistic children.

BY JOAN AREHART-TREICHEL

Researchers have identified some medications that help autistic youngsters socialize.

For example, when autistic children were given selective serotonin reuptake inhibitors (SSRIs) or atypical antipsychotics in open-label studies, they became more spontaneous than before and interacted more with other people than before. However, these medications' putative ability to increase socialization in autistic youngsters has yet to be demonstrated in placebo-controlled trials. Also, it is not yet known whether the purported socialization benefits derive from a direct impact on socialization or via an indirect effect—say, by reducing irritability and anxiety.

Still another medication that looks promising for autistic children is the antibiotic D-cycloserine, a pilot study reported in the November *American Journal of Psychiatry* suggests. The study was headed by David Posey, M.D., an assistant professor of psychiatry at Indiana University and director of the university's autism treatment center.

Various factors prompted Posey and his colleagues to undertake a pilot study to determine whether D-cycloserine might increase socialization in autistic children. In addition to being used to treat tuberculosis for 45 years, D-cycloserine enhances the activity of the neurotransmitter glutamate in the brain. Adding low doses of D-cycloserine to antipsychotics other than clozapine can temper social withdrawal in persons with schizophrenia, several studies have suggested. D-cycloserine has been safely used in children at high doses to treat tuberculosis, and the low doses of D-cycloserine used in persons with schizophrenia have produced limited side effects.

In the pilot study by Posey and his coworkers, 10 individuals who met a *DSM-IV* diagnosis of autism and who were on average 10 years old received a placebo for two weeks, then three different, ascending doses of D-cycloserine during each of three two-week periods. The daily doses were about 0.7 mg/kg, 1.4 mg/kg, and 2.8 mg/kg, respectively. The subjects' social withdrawal was measured with four yardsticks at the start of the study, at the end of the placebo phase, and at the end of each two-week phase. The yardsticks were the Clinical Global Impression Scale, the Social Responsiveness Scale, a modified Children's Yale-Brown Obsessive-Compulsive Scale, and the Aberrant Behavior Checklist.

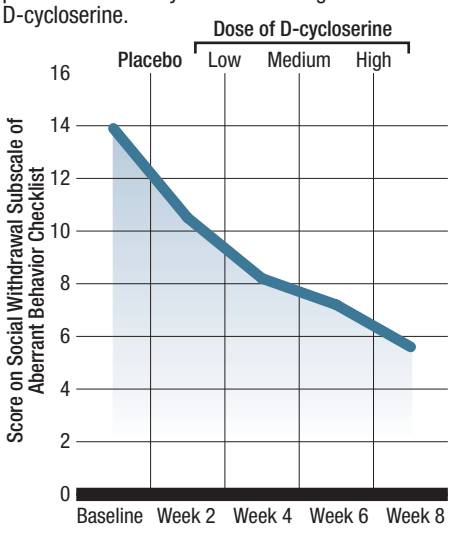
Test results were encouraging. For example, subjects performed significantly better on the Clinical Global Impression Scale after they had received the medium and high doses of D-cycloserine than they had at the start of the study. Subjects performed significantly better on the social withdrawal subscale of the Aberrant Behavior Checklist after they had gotten the highest dose of D-cycloserine than they had at the start of the study (see chart). In four of 10 subjects, social improvement was clinically meaningful.

One of these four subjects was 5-year-old "Greg." Greg had been in individual speech therapy and in group social skills training with a speech and language therapist for two years. The therapist was not informed about Greg's participation in the D-cycloserine study. Nonetheless, she noted marked improvement in his attention, spontaneous use of language, and initiation of social interaction while he was on D-cycloserine.

The pilot study was financed by the National Alliance for Research on Schizophrenia and Depression (NARSAD), the National Institutes of Health, a Daniel X. Freedman Psychiatric Fellowship Award, and the U.S. Department of Housing and Urban Development.

Improvement Seen

Ten autistic subjects experienced less social withdrawal over eight weeks after receiving placebo followed by three escalating doses of D-cycloserine.



Source: *American Jounral of Psychiatry,* November 2004

A randomized, double-blind, placebo-a controlled trial to further explore D-cycloserine's impact on socialization in autistic subjects got under way earlier this year, Posey told *Psychiatric News.* It is being funded by the National Institute of Mental Health and NARSAD.

The study, "A Pilot Study of D-Cycloserine in Subjects With Autistic Disorder," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/11/2115?>. ■

Insulin

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subjects and the Alzheimer's subjects performed significantly better after getting insulin than getting a placebo, and the effect was even greater in the latter.

Another pilot trial by Craft and coworkers, in fact, suggests that giving a medication that boosts insulin's activity may be a way of halting memory loss in Alzheimer's patients. The medication is rosiglitazone, which is used to treat insulin resistance linked with type 2 diabetes. Results of this trial were reported at the Ninth International Conference on Alzheimer's Disease and Related Disorders in July.

GlaxoSmithKline, rosiglitazone's manufacturer, is conducting a larger trial to explore further the medication's seemingly salutary effect on memory in Alzheimer's.

How insulin might improve memory remains to be determined. Intranasally administered insulin is known to enter the cerebrospinal fluid, and insulin receptors have been detected in the hippocampus, a prime memory center in the brain.

And while the means by which rosiglitazone might stop memory loss in Alzheimer's patients is unknown, scientists suspect that it may not only alter brain levels of insulin, but also change brain levels of beta-amyloid protein—purportedly a major culprit in the Alzheimer's disease process.

An abstract of the study, "Intranasal Insulin Improves Memory in Humans," can be accessed online at <www.sciencedirect.com> by clicking on "Browse Journals," "P," and then "Psychoneuroendocrinology." The two studies reported by Craft and coworkers at scientific meetings are under review by scientific journals. Information about the GlaxoSmithKline rosiglitazone memory trial can be obtained by e-mail at Marcus.E.Risner@gsk.com. ■

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Parents With Mental Illness Face Daunting Challenges

Child-rearing can be a challenge for anyone. Yet the difficulties facing parents with serious mental illness can be overwhelming, and psychiatrists can help these patients by starting a dialogue about parenting.

BY EVE BENDER

People with serious and persistent mental illness often face unique issues surrounding their role as parents, issues that should be addressed during psychiatric treatment, according to a panel of Baltimore-area psychiatrists who spoke at APA's Institute on Psychiatric Services in Atlanta in October.

Some of these issues include losing custody due to repeated hospitalizations, being unable to care for a child due to debilitating psychiatric symptoms, or needing the support of family members to raise a child.

"In an opening dialogue with patients, we tend not to ask questions about parenting," noted Ann Hackman, M.D., medical director of the Programs for Assertive Community Treatment (PACT) team at the University of Maryland Medical System in Baltimore.

Although questions such as "Have you ever had children?" often come up during the initial assessment, she said, "we don't necessarily get back to them." This is the case with both men and women patients, she added.

Giving patients the opportunity to talk about their feelings about parenting is important, she noted.

Clinicians should determine the level of the patient's involvement with his or her child and address whether problems such as psychiatric symptoms, homelessness, or substance use interfere with the parent-child relationship.

One of Hackman's patients told her she would have loved to have children, but began experiencing symptoms of serious mental illness at age 17 and was never able to maintain a relationship with a significant other. For that reason, the woman never felt she could have children. "That's a loss that merits discussion," Hackman said.

Curtis Adams, M.D., sometimes prescribes dates for overburdened couples who care for relatives with serious mental illness.

Hackman sometimes hears from patients that medication side effects or psychiatric symptoms "impact dramatically on the ability to be the parent they would have liked to be," she said.

Psychiatrists can help patients who are parents in other ways as well, such as helping them manage visitation of their children or get involved in parenting classes and peer support groups, such as a women's support group at the University of Maryland Medical System.

"Often a family is a tyranny ruled by its sickest member."

In the group, Hackman noted, women may discuss "how to strengthen the relationships they have with their children or how they were able to successfully raise their children despite repeated hospitalizations."

In addition, she said, some support-group members "talk for the first time about the trauma of having their children taken away from them."

Theodora Balis, M.D., a member of the PACT team, said societal stigma "may have led many to believe that parenting is not highly valued by people with mental illness" and that "women with serious mental illness have multiple partners and above-average fertility rates," which all have been disproved by scientific literature.

The proportion of women with serious mental illness who lose custody of their children ranges from 30 percent to 60 percent, depending on the study, Balis said.

She quoted sociologist Erving Goffman, Ph.D., who in 1961 wrote that "patients with serious mental illness are victimized twice as they first experience a devastating neurobiological illness through no fault of their own and then find themselves at risk for other losses including losing their children. . . .They are viewed as permanently flawed and incapable of fulfilling one of society's most cherished roles."

Balis noted that many psychiatric patients lose custody of their children during hospitalization. Fear of losing custody of

please see ***Parents*** *on page 44*

For Youngsters With OCD, CBT Tops Medication

Results from the NIMH Pediatric OCD Treatment Study again suggest psychotherapy is the way to go.

BY JIM ROSACK

A new study is challenging the status quo with data suggesting that obsessive-compulsive disorder (OCD) in children and adolescents is more amenable to treatment with psychotherapy than with the standard medications prescribed for many years.

The Pediatric OCD Treatment Study (POTS) was a randomized, controlled trial looking at the efficacy of cognitive-behavioral therapy (CBT) alone compared with the SSRI sertraline (Zoloft) alone, combined CBT and sertraline, and placebo over the course of 12 weeks. The study was funded by the National Institute of Mental Health.

"The basic take-home message from this study is that initial treatment for children and adolescents with OCD needs to include cognitive-behavioral psychotherapy—either alone or in combination with medicine," said John March, M.D., M.P.H., a professor of psychiatry at Duke University Medical Center and principal investigator of the trial. The POTS results were published in the October 27 *Journal of the American Medical Association*.

"While medication alone is effective for OCD," March told *Psychiatric News*, "it is not as effective as the CBT-containing treatments, and it is troubling and probably no longer acceptable just to rely on medications as monotherapy for pediatric OCD."

Study Builds on Past Work

POTS is the third combined-modality treatment study sponsored by NIMH in pediatric populations, March noted. The first was the Multimodal Treatment of ADHD (MTA) study, led by Columbia University's Peter Jensen, M.D.; the second was March's Treatment of Adolescent Depression Study (TADS) *(Psychiatric News*, September 3). Interestingly, he added, the MTA noted no advantage to combined treatment with medication and psychotherapy, while the TADS found that combined treatment was more effective than either treatment alone.

"With POTS, the combination was superior, but not all that much so, to CBT alone," March said, "and both the CBT-containing treatments were better than medication alone, which was better than placebo. So unlike depression in kids and teens, with OCD it seems to be the psychotherapy that is the big winner."

March emphasized that the disparate results with medication compared with therapy or the combination for treating pediatric disorders "tells us something about these disorders and what their etiology is."

He continued, "We really have to think about these disorders as individual conditions that require treatments that are tightly coupled to their targets—whether you conceptualize those targets as behavioral/symptomatic targets or intermediate phenotypes, as in the allocation of attentional resources, or whether you conceptualize them as neural networks with their own particular neuroanatomy. You have to conceptualize these disorders as highly individualized, and one can no longer simply say that one size [of treatment] fits for all."

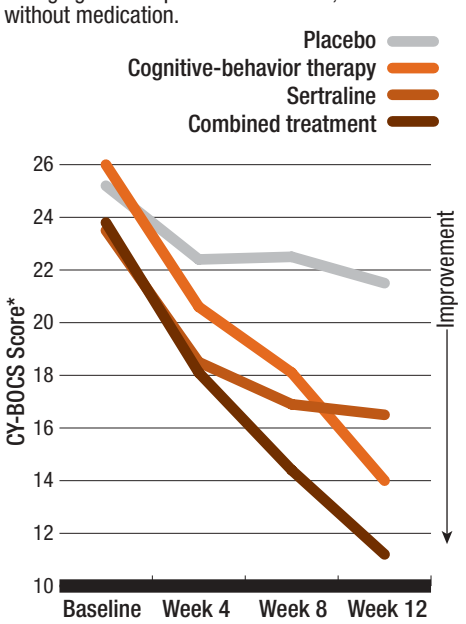
Methodology Detailed

POTS enrolled 112 patients aged 7 through 17 at three academic medical centers in the United States, all with a *DSM-IV-TR* diagnosis of OCD and a score of 16 or higher on the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS). Patients were randomly assigned to one of the three treatment modalities or placebo for 12 weeks. The primary outcome measure was the change in CY-BOCS scores over the 12 weeks of treatment, as rated by an independent evaluator who was kept blind to treatment status. A secondary outcome measure was the rate of clinical remission of OCD, defined as a CY-BOCS score of 10 or less.

All three active treatments showed statistically significantly greater improvement over the study's 12 weeks, compared with placebo. Combined treatment also proved superior to CBT alone and to sertraline alone; however, CBT and sertraline did not differ statistically significantly from one another (see graph).

Psychotherapy Matters

Psychotherapy appears to be a vital component of changing an OCD patient's behaviors, with or without medication.



* Children's Yale-Brown Obsessive-Compulsive Scale
Source: *JAMA*, October 2004

Rates of clinical remission were 53.6 percent for combined treatment, 39.3 percent for CBT alone, 21.4 percent for sertraline alone, and 3.6 percent for placebo. Statistically, remission rates were not different between the combined treatment and CBT alone, and CBT alone did not differ significantly from sertraline alone, but was statistically superior to placebo. Sertraline alone was not statistically superior to placebo on remission rates.

With regard to safety, two patients taking sertraline experienced "activation" that presented as "increased motor activity" or "impulsivity." The activation subsided with dosage adjustments. Five patients on sertraline and one on placebo exhibited mild activation symptoms that included mild increases in motor activity but no corresponding increase in impulsivity.

"We had 56 kids on sertraline and 28 allocated to placebo," March noted. According to the FDA's estimate of suicidal thoughts and behaviors associated with SSRI antidepressants, the researchers would have expected to have two subjects with suicidality, but "we found none. This study was really too small to say anything except that we saw really no hint at all of any suicidality in any of these kids. Also, we saw no mania, hypomania, disinhibition, or increased anxiety—all things that people point to in support of the suicidal association."

March and his team are continuing their work with the same group of children. "The kids who were responders went on into a discontinuation trial, where we stopped their treatment. The nonresponders were referred for treatment that was appropriate for their particular clinical situation. But what we really want to see, using survival analysis," he concluded, "is how many patients relapse over the subsequent four months."

Those data have not been analyzed yet, March said. He hypothesized that youngsters on CBT would relapse less than the those on sertraline, but it will be interesting to see whether that hypothesis pans out, he said.

An abstract of "Cognitive-Behavior Therapy, Sertraline, and Their Combination for Children and Adolescents With Obsessive-Compulsive Disorder" is posted online at <http://jama.ama-assn.org/cgi/content/abstract/292/16/1969>. ■

Sleep Experts Wake Up to Value Of CBT for Insomnia

Patients are better off avoiding "the quick fix" of hypnotic medications for insomnia. Instead, they should turn to CBT to learn how to fall asleep and stay asleep through the night.

BY JIM ROSACK

Researchers at Harvard Medical School have shown that patients with chronic sleep-onset insomnia see greater improvement from a course of cognitive-behavioral therapy (CBT) than they do from the market-leading hypnotic medication zolpidem (Ambien).

The study, reported in the September 27 *Archives of Internal Medicine*, was a randomized controlled trial involving 63 adults with chronic sleep-onset insomnia. The research was funded by grants from the National Institutes of Health and National Institute on Drug Abuse.

Patients were randomly assigned to CBT, pharmacotherapy (with zolpidem), a combination of CBT and zolpidem, or placebo. Those in the CBT group received five 30-minute sessions over six weeks. The patients were given daily exercises to teach them to "recognize, challenge, and change stress-inducing thoughts," according to the study's lead author, Gregg Jacobs, Ph.D., an assistant professor of psychiatry at Harvard and a researcher at the Harvard-affiliated Sleep Disorders Center at Beth Israel Deaconess Medical Center.

Patients were taught techniques such as delaying time of going to bed or getting up to read if they were unable to fall asleep within about 20 minutes of going to bed, Jacobs said in a press release.

Those assigned to receive zolpidem started with 10 mg a night for the first 28 nights (four weeks) of the eight-week treatment period. For the following seven days (week 5), they received 5 mg a night, and then 5 mg every other night for an additional week (week 6). No medication was taken during the final two weeks.

Patients randomly assigned to receive placebo followed the same protocol as the medication group without any CBT or "sham therapy."

Jacobs was surprised at what he and his team found.

"Sleeping pills are the most frequent treatment for insomnia, yet CBT techniques clearly were more successful in helping the majority of study participants to become normal sleepers. The pills were found to be only moderately effective compared with CBT, and lost their effectiveness soon after they were discontinued."

All patients kept sleep diaries for 14 days before treatment began, for 14 days at mid-treatment (weeks 3 and 4), and for 14 days after treatment ceased (the end of the protocol). In addition, patients underwent three nights of home-based "nightcap" recordings before and after treatment. The "nightcap monitor" is a two-channel sleep monitor that measures sleep-onset latency as well as other measures of sleep by using eyelid- and head-movement sensors attached to a small, battery-operated recorder placed under the bed pillow.

The CBT and the combination groups showed the greatest changes in sleep-onset latency at mid-treatment, with both groups showing a 44 percent reduction in the amount of time it took to fall asleep at bed time. Those taking zolpidem showed only a 29 percent reduction, and those on placebo had only a 10 percent reduction in sleep latency. By the end of week 8, the CBT and combined treatment group each yielded a 52 percent reduction in sleep onset. These significant improvements were maintained for the follow-up period of 18 months, whereas improvements seen in the zolpidem group were not maintained over the long term. In fact, Jacob pointed out, "by the end of the eight-week treatment phase, insomnia returned to baseline levels and did not differ from [those of] the placebo group."

Intriguingly, no significant differences emerged among the groups in terms of total sleep time, though each group exhibited some increase.

"Our results suggest CBT should now be considered the first-line treatment for insomnia, which is experienced on a nightly basis by one-third of the nation's adult population," Jacobs concluded.

An abstract of "Cognitive-Behavior Therapy and Pharmacotherapy for Insomnia" is posted online at <http://archinte.ama-assn.org/cgi/content/abstract/164/17/1888>. ■

COMPILED BY JIM ROSACK

Regulatory and Legal Briefs

• Janssen's Reminyl brand of ***galantamine*** is being confused with Aventis's Amaryl brand of ***glimepiride***. In cooperation with the Food and Drug Administration (FDA), Janssen issued a "Dear Pharmacist" letter warning of confusion between Janssen's product for Alzheimer's disease and the Aventis product for treatment of type 2 diabetes. According to medication error reports, prescriptions have been "incorrectly written, interpreted, labeled, and/or filled due to the similarity in names between Reminyl and Amaryl," the letter says.

Adding to the confusion, the dosage strengths of the two drugs are similar, and both are dispensed as tablets. Also, the similarity not only in brand names, but also in generic names has resulted in some pharmacies stocking the two products in close proximity to each other within the "G" section of drugs.

Patients with Alzheimer's disease who have received the antidiabetic medication rather than their correct prescription have developed serious cases of hypoglycemia. At least one death has been attributed to the confusion.

• ***OROS-methylphenidate*** was approved by the FDA in October in a new daily dosing regimen of 72 mg for use in adolescents with attention-deficit/hyperactivity disorder. Previously, the drug was prescribed off label as two 36 mg tablets each day for patients who have inadequately responded to doses up to the previously approved maximum of 54 mg a day. Tablets are currently available in 18 mg, 27 mg, 36 mg, and 54 mg strengths. No 72 mg tablet will be available.

• An orally disintegrating form of ***donepezil*** has been approved by the FDA for treatment of mild to moderate Alzheimer's disease. The new dosage form, to be marketed as Aricept ODT in the United States, may help patients who have difficulty swallowing. It should be available by the second quarter of 2005 in blister packaging, with the same dosages available in tablet form. The orally disintegrating form was approved in Japan in February 2004, and Pfizer/Eisai also submitted an application for approval to the European Union in December 2003, which is pending.

• The FDA determined on October 15 that the Serzone brand of ***nefazodone*** was not withdrawn from sale for reasons of safety or effectiveness. Serzone's manufacturer, Bristol-Meyers Squibb (BMS), voluntarily removed it from the market effective June 14. At the time BMS cited "commercial business reasons," particularly declining sales and increased generic competition. However, the Public Citizen Health Research Group had petitioned the FDA on March 6, 2003, to remove the product from the market immediately because of severe adverse events involving serious (and sometimes fatal) cases of liver toxicity. The formal determination by the FDA is partly in response to that petition.

While the brand was withdrawn by BMS, generic formulations continue to be marketed. Public Citizen sought the removal of all forms of the drug on safety grounds. The FDA's determination allows generic nefazodone to continue to be marketed. The United States is the only country where nefazodone remains available.

• Pfizer has completed its settlement resolving criminal and civil charges related to its Neurontin brand of ***gabapentin***, which it inherited in its merger with Warner-Lambert. The company agreed in May to pay $430 million to the federal government to settle charges that it paid doctors to prescribe the epilepsy drug for disorders for which it was not approved. Under federal "whistle-blower" statutes, a former Warner-Lambert medical officer, David P. Franklin M.D., stands to receive $26.64 million of the total paid. With $2.7 billion in worldwide sales last year, nearly 90 percent of Neurontin prescriptions continue to be for off-label uses. The federal case was brought by U.S. attorneys in Boston and Philadelphia.

Research Briefs

• ***Nortriptyline*** added to transdermal nicotine therapy may significantly boost a patient's chance of quitting smoking. In a randomized controlled trial of 158 patients, those taking nortriptyline along with the nicotine patch had higher cessation rates at six months (23 percent), compared with those on placebo and the nicotine patch (10 percent). While cessation rates increased with nortriptyline, nicotine withdrawal symptoms were not significantly different between the two groups. Nortriptyline therapy was associated with significant, frequent adverse effects including dry mouth (38 percent of patients) and sedation (20 percent).
Arch Intern Med 2004; 164:2229-2233

• ***Risperidone*** may be effective in reducing core deficits associated with pervasive developmental disorders and autism. In a double-blind, randomized trial involving 79 children, aged 5 to 12, risperidone was associated with significantly greater reductions in irritability compared with placebo (64 percent reduction versus 31 percent) and was also associated with improvements in conduct, insecure/anxious behaviors, hyperactivity, and social sensitivity. Global improvement occurred in 87 percent of children taking risperidone compared with 40 percent taking placebo. The most frequent adverse effects noted in patients taking risperidone were somnolence, weight gain, and increases in pulse rate and blood pressure.
Pediatrics 2004; 114:e634-e641

• ***Duloxetine*** is an option for the treatment and management of major depressive disorder, according to a review of published as well as unpublished clinical trials and poster abstracts presented at professional meetings. The serotonin-norepinephrine reuptake inhibitor is effective in depression at daily doses between 40 mg and 60 mg and has been studied extensively in stress urinary incontinence and diabetic neuropathic pain as well. Clinical trials investigating the use of duloxetine in the treatment of anxiety and fibromylagia are under way. Seven clinical trials have been published on duloxetine use for major depression, involving 3,500 adult patients, over eight weeks to one year of treatment.

All seven trials have been positive with respect to efficacy. The most frequent adverse effects associated with duloxetine therapy in clinical trials for any indication have included headache (20 percent to 26 percent), rhinitis (16 percent to 19 percent), asthenia (14 percent to 17 percent), anorexia (12 percent to 13 percent), nausea (13 percent to 46 percent), constipation (11 percent to 14 percent), insomnia (11 percent to 20 percent), diarrhea (9 percent to 19 percent), and somnolence (8 percent to 21 percent).
Ann Pharmacother 2004; 38:2078-2085; published online ahead of print November 2, 2004, at <www.theannals.com>

• ***Fluoxetine*** significantly delays relapse of major depressive disorder in children and adolescents. A 32-week, relapse-prevention study was completed as a continuation phase of a randomized, double-blind, 51-week study. Twenty patients who were randomized to fluoxetine continued on fluoxetine for the additional 32 weeks, while 20 patients who were randomized to fluoxetine for 51 weeks were switched to placebo for the additional 32 weeks. The average time to relapse was significantly longer in patients remaining on fluoxetine. Relapse occurred in 34 percent of those continuing fluoxetine therapy compared with 60 percent of those switched to placebo.
J Am Acad Child Adol Psychiatry 2004; 43(11):1397-1405

Industry Briefs

• ***Dexmethylphenidate–extended release*** is a safe and effective alternative for treatment of both children and adults with attention-deficit/hyperactivity disorder. In three company-sponsored research presentations at the annual meeting of the American Academy of Child and Adolescent Psychiatry in Washington, D.C., in October, results showed suppression of core symptoms was significantly greater with dexmethylphenidate–extended release compared with placebo in a six-month clinical trial involving 221 adults randomized to daily doses of 20 mg, 30 mg, or 40 mg. Similar results were seen in two pediatric trials, one of which compared the drug with placebo in 103 patients aged 6 to 17, and the second of which evaluated a daily dosing regimen of 20 mg in 54 children aged 6 to 12 who had previously been stabilized on 20 mg to 40 mg of methylphenidate a day. Both pediatric studies showed positive results. Adverse events were similar in pediatric and adult patients and were consistent with those known to be associated with methylphenidate, including headache, insomnia, and decreased appetite.

• ***ACP-103,*** Acadia Pharmaceuticals' novel 5-HT_{2A} inverse agonist, may significantly reduce motor disturbances and hyperprolactinemia associated with antipsychotic therapy. A double-blind, phase II clinical trial involving 18 healthy volunteers showed the investigational drug blocked akathisia associated with haloperidol administration and reduced the hyperprolactinemia associated with the typical antipsychotic by 35 percent. Acadia is developing the drug as a novel therapy to be used in combination with atypical antipsychotics as well, and trials are planned with olanzapine, risperidone, and quetiapine. ■

Medication Names and Manufacturers

The following medications appear in this edition of Med Check:

• **Dexmethylphenidate-extended release:** Focalin XR (Novartis) (investigational)
• **Donepezil-orally disintegrating:** Aricept ODT (Eisai/Pfizer) (investigational)
• **Duloxetine:** Cymbalta (Eli Lilly)
• **Fluoxetine:** Prozac/Serafem (Lilly); generics
• **Gabapentin:** Neurontin (Pfizer)
• **Galantamine:** Reminyl (Janssen)
• **Glimepiride:** Amaryl (Aventis)
• **Haloperidol:** Haldol (McNeil); generics
• **Methylphenidate:** Ritalin (Novartis); generics
• **Nefazodone:** generics
• **Nicotine–transdermal:** NicoDerm CQ (GlaxoSmithKline); generics
• **Nortriptyline:** Pamelor (Novartis); generics
• **Olanzapine:** Zyprexa (Lilly)
• **OROS-Methylphenidate:** Concerta (McNeil)
• **Quetiapine:** Seroquel (AstraZeneca)
• **Risperidone:** Risperdal (Janssen)

Nominations Invited

Do you know someone who has made a lasting contribution to the fight against depression? If so, you can consider nominating them for one of the annual Welcome Back Awards.

Now in its seventh year, the program, sponsored by Eli Lilly and Company, bestows the awards in the following five categories:

• Lifetime achievement, which is given to a person whose successful battle to overcome depression "serves as an inspiration to patients and health care professionals."
• Destigmatization, which is given for public efforts to promote understanding of and reduce the shame that can accompany depression.
• Community service, which honors a mental health advocate who has created or improved community-based depression programs.
• Primary care, which recognizes any health care professional "whose consistent, caring approach to treating patients serves as an example for others."
• Psychiatry, which honors a psychiatrist's outstanding efforts in depression research or treatment.

The Lifetime Achievement Award comes with a $15,000 gift to a nonprofit organization chosen by the recipient, and the other four come with a $10,000 gift.

Nominations can be made by phone at (800) 463-6440 or online at <www.WelcomeBackAwards.com>. The deadline for receipt of nominations is December 31.

WYETH EFFEXOR P4C

WYETH EFFEXOR

P4C

Can Luncheon Behavior Foretell Schizophrenia?

Adolescents who exhibit less smiling, laughing, and talking while lunching may later develop schizophrenia. An adolescent psychiatrist describes the finding "amazing."

BY JOAN AREHART-TREICHEL

Could youngsters' behavior while eating lunch predict which ones will develop schizophrenia? It sounds rather improbable, but perhaps, a study reported in the November *American Journal of Psychiatry* suggests. The study was headed by Jason Schiffman, Ph.D., an assistant professor of psychology at the University of Hawaii at Manoa.

Some 9,000 children were born in a particular hospital in Copenhagen, Denmark, between 1959 and 1961. In 1972, when the children were between 11 and 13 years of age, some 250 were selected for an investigation into the early signs of schizophrenia. A number of these adolescents had a parent with schizophrenia and thus were at high risk for developing the illness.

One aspect of the study consisted of videotaping the youngsters while eating lunch to record their social behavior and neuromotor skills. Lunch consisted of Danish open-face sandwiches constructed in layers and requiring some motor skills to consume.

These adolescents were followed up in 1992, when they were between the ages of 31 and 33, to determine whether any of them had been diagnosed with schizophrenia or other psychiatric disorders.

Now Schiffman and his colleagues have used videotaped lunch behaviors from some 150 of the adolescents to determine whether the social behavior and neuromotor functioning of those who later developed schizophrenia differed from those who later had no mental illness or another mental disorder.

The researchers found that the adolescents who later developed schizophrenia had, on average, a lower total score on a sociability scale including smiles, laughs, and vocalizations than did adolescents who developed other kinds of psychopathology or remained free of mental disorder. Boys who later developed schizophrenia scored, on average, higher on a neuromotor scale consisting of involuntary facial movements, raised elbows, nystagmus-like eye movements, and other abnormal movements than did boys who developed other psychopathology or none.

In an accompanying editorial, Gabrielle Carlson, M.D., a child-adolescent psychiatrist and professor of psychiatric and pediatrics at the State University of New York at Stony Brook, wrote: "Prospective follow-up studies are treasures. . . . That a videotape of a casual interaction can detect children at risk for schizophrenia because they smile, laugh, and initiate conversation less often than nonaffected peers is amazing. . . ."

Fewer grins and chuckles and less chitchat, of course, are no guarantee that youngsters will develop schizophrenia.They may have a naturally reticent nature or perhaps suffer from another mental condition such as social anxiety. "Depression and pervasive developmental disorder can also dampen expressions of happiness and volubility in youth," Carlson told *Psychiatric News.*

So what is needed at this juncture, she said, is further research to examine the sensitivity and specificity of these findings and whether they might be used in conjunction with teacher ratings and parent ratings to identify youth at high risk of schizophrenia. However, "I am not aware of any studies of this nature being done," she said.

Schiffman and his coworkers are conducting another study that should further reveal whether adolescent lunch behaviors might predict schizophrenia. The project, he explained to *Psychiatric News*, "is a more in-depth analysis of the youth from the current study combining various neurological measures of functioning to increase the predictive ability to detect schizophrenia. In addition to the videotaping conducted for this report, various other indices of neurological functioning were gathered. We anticipate that by combining these predictors, we might not only learn more about the neurodevelopmental basis of schizophrenia, but also gain clinically predictive utility among youth at genetic risk for schizophrenia."

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

The study, "Childhood Videotaped Social and Neuromotor Precursors of Schizophrenia: A Prospective Investigation," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/11/2021?>. ■

ASTRAZENECA SEROQUEL (DELIVERY) P4C

Beyond Scientific Method

The article headed "Programs Try to Restore Luster to Psychodynamic Psychotherapy" in the June 18 issue reported that all graduating psychiatry residents are now required to demonstrate competence in five core psychotherapy treatment options, including psychodynamic psychotherapy.

One course being offered presents "some of the scientific evidence underpinning psychodynamic psychotherapy." Scientific evidence may help restore the prominence, popularity, and respect for psychodynamic psychotherapy, but the scientific method has its limitations. It is based on comparing groups. If individuals fit into groups that have been studied, there is a statistical probability that the outcomes of the group studies apply to an individual. Scientific method cannot study or evaluate a single unit, a single individual.

In contrast, psychoanalysis or psychodynamic psychotherapy of a single patient is a method of studying and evaluating a single individual. The analytic process has an internal, logical, and rational approach throughout. Even in one session, a patient's statements at the beginning of a session are compared with statements during and at the end of the session.

This same rational process applies throughout an analysis. Statements and reports about mental pictures, feelings, and behaviors are continually cross-checked and compared. Inductive reasoning proposes hypotheses that are repeatedly confirmed or contradicted. In the latter case new hypotheses are formed. Thus, the study of an individual is continually being developed. The probabilities (to borrow a scientific term) of valid conclusions about an individual are gradually increased.

While we are in debt to scientific methods for much knowledge and information, and science-based treatment will always be important to treatment of individuals, it is time for professionals to stop worshiping the scientific method as if it were the only source of knowledge and information and accept that it cannot study or evaluate a single individual and produces only probabilities for an individual patient.

It is time to start appreciating the rational and logical approach of psychodynamic psychotherapy for producing probable knowledge and information about an individual patient.

JAMES M. MURPHY, M.D.
New York, N.Y.

Falun Gong

For all the good work and intentions of APA representatives on the World Psychiatric Association (WPA), it seems that the latter body hasn't learned from past experience:

Those who served on the WPA during the years that psychiatric abuse of both patients and psychiatrists was taking place in the former Soviet Union learned that the higher echelons of Soviet psychiatry were in fact either apologists for the state, lacked the courage to oppose the abuses, or were active participants in the abuse. The infamous diagnosis of "sluggish schizophrenia" is a classic example of how far eminent Soviet psychiatrists were prepared to go to cover the abuses.

Now in China we see the emergence of the diagnosis of "quigong psychosis" to validate the psychiatric treatment and incarceration of the practitioners of Falun Gong and political dissidents.

The abusive use of psychiatry in China cannot occur without the compliance of Chinese psychiatrists. Regrettably, we cannot punish the state without punishing Chinese psychiatry. This lesson was hard won from the Soviet experience. There are times when it is indeed better to be cruel in the present to be kind in the long run. We, as an association, need to demand that the WPA actively pursue the requirements it expected of Chinese psychiatry at the International Congress in Yokohama, with the understanding that expulsion will follow if they fail to fulfill those requirements *(Psychiatric News*, November 1, 2002). Collegial discussions and scientific meetings will not suffice.

D. RAY FREEBURY, M.D.
Past Chair
APA Committee on International Abuse of Psychiatry

State Hospital Training

Inpatient psychiatry training is an essential aspect of residency programs and a requirement for board certification in psychiatry. Most inpatient psychiatry training occurs within university hospitals, community hospitals, and VA hospitals. But there is one more type of hospital to which few residents are exposed—the state hospital. That needs to be changed.

State hospitals have patient populations and provide treatment on a basis different from other hospitals. State hospitals still provide longer hospitalizations and care for the most chronically mentally ill patients.

In addition, state hospitals have forensic units and units with specialized psychiatric populations, such as violent sexual predators, with whom residents do not commonly have an opportunity to work. Moreover, when residents—or later on as full-fledged psychiatrists—need to transfer patients to state hospital units, exposure to state hospitals will enable them to communicate more effectively with the staff psychiatrists there.

Inpatient state hospital training provides specialized education, awareness, and depth to inpatient psychiatry training, and both residents and state hospitals can benefit from it.

MOHAMED RAMADAN, M.D.
Wichita, Kan.

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.

FOREST NAMENDA

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FDA

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at least two instances of FDA medical reviewers who identified early warning signs of possible safety concerns, only to be allegedly silenced by their FDA superiors.

On the antidepressant issue, medical reviewer Andrew Mosholder, M.D., identified his concerns in a memo to superiors regarding his suspicion of an increased incidence of suicidal thoughts and behaviors in children and adolescents who had depression and were taking SSRI antidepressants. Mosholder's concerns and subsequent recommendations for further study and potential warnings were allegedly squelched by his superiors, and his report was yanked at the last minute from the agenda of the February meeting of the Psychopharmacologic Drugs Advisory Committee.

Similarly, early concerns raised by another FDA medical reviewer regarding the cardiovascular safety of rofecoxib were allegedly ignored for years, and the reviewer was disciplined and reassigned.

Crawford's third point in the plan is to step up the search for a director of the Office of Drug Safety, a position that has been vacant for close to a year. A national search will be conducted for a candidate "who is a nationally recognized drug safety expert with knowledge of the basic science of drug development and surveillance," Crawford said, "and has a strong commitment to the protection of public health."

Fourth, CDER will conduct over the next year a series of workshops and advisory committee meetings to discuss "complex drug safety and risk management issues." Topics may include emerging concern for products that are either already on the market or that are investigational. Input will be sought on how to balance the risks of a particular drug with its demonstrated benefits. This series of "risk management consultations" will likely involve FDA experts, scientists from other government agencies, academia, the pharmaceutical industry, and the health care community.

Lastly, Crawford announced, "By the end of this year, the FDA intends to publish final versions of three guidances that have been developed by our agency to help pharmaceutical firms manage risks involving drugs and biological products."

These documents, he noted, were issued as draft guidances in May (see box) and are designed to assist pharmaceutical companies in identifying and assessing potential safety risks before and after a drug reaches the market and "promote the use of good pharmacovigilance practices and pharmacoepidemiologic assessment."

Crawford said, "I am satisfied that these additional activities will strengthen the agency's program to greater ensure the safety of medical products that are making a major contribution to the health and quality of life of millions of Americans."

Crawford's statement is posted online at <www.fda.gov/bbs/topics/news/2004/NEW01131.html>. More information on the FDA's pilot program for resolving differing professional opinions regarding drug/product safety is posted online at <www.fda.gov/cder/mapp/4151.2.pdf>. ■

FDA Formulates Drug Safety Plan

Last month the FDA announced a five-step plan to strengthen the nation's drug safety program:

- Sponsor an Institute of Medicine study of the drug safety system.
- Implement a program for adjudicating differences of professional opinion.
- Appoint a director for the FDA Office of Drug Safety.
- Conduct drug safety/risk management consultations.
- Publish risk management guidances.

Below are the names and Web sites of the three draft guidances that the FDA issued in May to help pharmaceutical companies identify and assess potential safety risks before and after a drug reaches the market.

- **Premarketing Risk Assessment:** www.fda.gov/cder/guidance/5765dft.doc
- **Development and Use of Risk Minimization Action Plans:** www.fda.gov/cder/guidance/5766dft.htm
- **Good Pharmacovigilance Practices and Pharmacoepidemiologic Assessment:** www.fda.gov/cber/gdlns/pharmacovig.pdf

FOREST NAMENDA

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Walk

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Nininger acknowledged that the stigma surrounding mental illness was one of the most significant barriers to improving the mental health of Americans.

"The unfortunate reality is that many people don't recognize mental illness or are afraid to accept the fact that either they or a loved one might be suffering," he said. "If you feel a pain in your chest, you go to a doctor, but if you feel a pain in your soul or confusion or disorganization in your mind, you may not seek treatment for mental illness due to the stigma attached to these disorders."

The D.C. NAMIWalk was the perfect antidote to such stigma, Nininger pointed out. "When events like this attract a large crowd, it's such a reassuring way of saying it's OK to get help."

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

Applicants Sought

The APA/Shire Child and Adolescent Psychiatry Fellowship is seeking applications from PGY-1, -2, or -3 psychiatry residents. The deadline is December 15.

Three to five residents will be selected for their interest in pursuing work in child and adolescent psychiatry. They will receive travel, lodging, and related expenses for two APA annual meetings: the 2005 meeting in Atlanta and the 2006 meeting in Toronto.

Further information and application materials are posted online at <www.psych.org/edu/res_fellows/apashirefellow110604.pdf>. Information is also available from Jane Edgerton at (703) 907-8579. ■

Parents

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children for this reason may keep many people with mental illness from seeking treatment, she said.

Clinicians need to be educated about the likelihood that women with serious mental illness either have or may have children, and if they do have children, "parenting should be an important part of treatment planning and case management services," she said.

When people with serious mental illness become parents, it may become necessary for members of their extended families to step in and take over many of the roles the parent would normally assume, said Curtis Adams, M.D., an assistant professor of psychiatry at the University of Maryland and a member of the PACT team.

Parents or siblings of the person with mental illness may assume the role of guidance counselor or confidante of the relative's child because the ill relative may be unable to do so.

The family member may also need to educate the child about his or her parent's mental illness and even serve as interpreter for the parent.

In his work with family members of people with serious mental illness, Adams noted that "often a family is a tyranny ruled by its sickest member."

It is easy for family members to lose themselves in the responsibilities of caring for the sick relative and his or her children, he noted.

In some families, it is a couple who assumes these responsibilities and lose their lives together in the process of dealing with the relative's illness, Adams said. To help them regain their lives, he said, "If they haven't been on a date recently, I prescribe a date, and the next time I see them, I ask them where they went."

"It is important that the relative's illness not dominate their lives, and this can easily happen, especially where parenting issues are concerned," he added. ■

Internet

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reading about other's mental health problems.

Perhaps one of the most disturbing—and common—negative consequences of using Internet-based health forums is that users can get incorrect or even dangerous information online.

"It's been said that trying to get information on the Internet is like drinking from a fire hose, and you don't even know what the source of the water is," Rosenberg said.

She cited a study by Thomas K. Lissman, M.D., who examined information listed on 20 popular depression-related Web sites and found that the quality of the information presented on the sites was poor.

"Almost half of the sites made no mention of medications, psychotherapy, or professional consultation as suggested treatments for depression," noted the article, which appeared in the August 2001 *Psychiatric Services*.

People also may go online to seek "e-therapy" from professionals who advertise on the Internet as having medical degrees or Ph.D.s in psychology. Others just bill themselves as "counselors," Rosenberg pointed out, so it is not clear what credentialing process any of them have passed.

Offering mental health services through e-mail or another Internet forum puts both patients and clinicians at risk, Rosenberg said, due to a number of potential problems—the inability of providers to be able to assess accurately a patient's mental status via computer and the potential loss of confidentiality for patients who send sensitive medical information via e-mail, for example.

Despite these potential pitfalls, "Don't we have an obligation to try to reach psychiatric populations who don't present to our offices?" asked Angela Leon Guerrero, M.D., chief resident in psychiatry at the University of Texas Southwestern Medical Center.

Internet-based mental health forums may be beneficial to patients who don't have access to mental health treatment because, for example, they live in rural areas, are agoraphobic, or may be biased against conventional treatment, she said.

Physicians in at least one survey found their that patients benefited from seeking medical information on the Internet.

Leon Guerrero cited data from a 2002 survey of 800 British physicians by Henry W. Potts, Ph.D., in which 85 percent of the doctors reported their patients benefited from the Internet. About 44 percent said that their patients encountered problems during Internet searches, such as misinformation.

To aid patients in the search for reliable medical information online, the University of Oxford in England has established DISCERN, a brief questionnaire that provides users with a "valid and reliable way of assessing the quality of written information on treatment choices for a health problem."

The Web address for DISCERN is <www.discern.org.uk>. ■

RESPECT

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other chronic diseases at the primary care setting, so that it would not require additional staffing beyond what is already available.

Regier is head of APA's Office of Research and the American Psychiatric Institute for Research and Education.

"I think a major problem is probably disseminating it to the smaller office practices that don't have additional staff available and that don't already have a preexisting infrastructure of the type that the five organizations had," Regier said. "But if, in fact, this model can be demonstrated to be sustained, I think it will be a very nice contribution."

Regier added that the RESPECT model supports the close monitoring of antidepressant medication use—especially around suicidal ideation. "If physicians were using this kind of instrument on a routine basis, they would be able to address the safety issues that have been raised," Regier said.

The report, "Re-engineering Systems for the Treatment of Depression in Primary Care: Cluster Randomised Controlled Trial," is posted online at <www.depression-primarycare.org/images/pdf/bmj.pdf>. ■

Offenders

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But Steadman said that all of the real-world research from communities with existing programs has consisted of one-year follow-up studies.

"The major cost savings on the criminal justice side are the saved jail days," Steadman explained. "All the research in the field has shown that people who are diverted spend fewer days in jail, and you are saving expensive jail days because these are people who require high levels of security and have pharmacy needs in excess of the average person in jail.

"But when you divert to the community, they need medications, and many of these people need assertive community treatment teams," Steadman said. "They need housing, in many instances, and if you also provide supported employment programs to make them employable, and child care for women so they can participate in treatment and be re-employed, you are talking about intensive services, and the savings on the criminal side are shifted to the mental health side."

Steadman said a key to making treatment in the community work is enrollment of diverted patients into Medicaid, SSI, and SSDI programs. This is especially true for those individuals who are in jail and due to return to the community; in those cases, a process of enrollment needs to begin before they are released and on the streets, Steadman said.

The TAPA Center is a nonprofit agency whose headquarters is at Policy Research Associates Inc. in Delmar, N.Y. TAPA was funded by CMHS, an agency of the Substance Abuse and Mental Health Services Administration, to provide technical assistance and policy analysis for communities seeking to develop programs for diverting people with mental illness from jail into community-based treatment and supports.

The DBs represented at the conference included the Illinois Psychiatric Society, Massachusetts Psychiatric Society, New Jersey Psychiatric Association, New York State Psychiatric Association, Northern California Psychiatric Society, Ohio Psychiatric Society, Pennsylvania Psychiatric Society, and Southern California Psychiatric Society. A representative from the Washington Psychiatric Society attended the conference on behalf of the D.C. and Virginia DBs.

Toward the end of the conference, the DBs were divided up to "brainstorm" about what next steps may be necessary in each of their states or regions, with a report back to the larger group.

"Some reported they needed to do more homework about the needed coalitions in their district, and others had different ideas," Goin said. "We will be following up on their progress and hope this is the first of future programs with increased ability for outreach."

APA's Fact Sheet on Criminalization of People With Mental Illness and Jail Diversion is posted online at <www.psych.org/advocacy_policy/leg_issues/CriminalizationofPeoplewithMentalIllnessesandJailDiversion.pdf>. The proceedings from the February conference are posted at <www.psych.org/edu/other_res/lib_archives/archives/200401.pdf>. ■

Serial Killer

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his head but could not pull the trigger, she added.

Ultimately, loyalty to Muhammad prevailed.

Malvo admitted to Schetky that he participated in the killings because, he said, "I was desperate to fill a void in my life, and I was ready to give my life for him."

As an expert witness for the defense at Malvo's trial, Schetky testified to the adversities of Malvo's childhood, "all of which led to a sense of powerlessness and a lack of a cohesive self-image," she said. She added that he had "no sense of identity apart from Muhammad."

Schetky said Malvo was "impaired in his ability to perceive risk and demonstrated fragmented consciousness and dissociative tendencies," which Malvo developed as a child to endure his mother's beatings.

On the witness stand, Schetky stated that as a result of Malvo's indoctrination by Muhammad, "Lee had dissociative disorder NOS, which interfered with his appreciation of the wrongfulness of his behavior."

However, the jury in that case found Malvo criminally responsible for the death of one of the sniper victims, Linda Franklin, but rejected the death penalty.

In late October, Malvo pleaded guilty to two other sniper shootings—those of Kenneth Bridges and Caroline Seawell—in Spotsylvania County, Va., and agreed to drop his pending appeals in the Franklin case.

Malvo is now serving a life sentence without possibility of parole at Red Onion State Prison in Wise County, Va. ■

Bullying

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Studies such as this, she said, may also help psychiatrists "convince schools of the importance of developing and implementing effective programs to reduce bullying. . . . Many psychiatrists see children who are victims and/or perpetrators of bullying and realize they are limited in what they can do in working with the child and parents alone. . . . We have come a long way from seeing bullying as normal, but we have a long way to go to make all our schools free of it."

The American Health Behavior in School-Aged Children Study was funded by the National Institute of Child Health and Human Development. Each country involved in the study obtained its own funding.

An abstract of the study, "Cross-National Consistency in the Relationship Between Bullying Behaviors and Psychosocial Adjustment," is posted online at <http://archpedi.ama-assn.org/cgi/content/abstract/158/8/730. ■

PFIZER GEODON IM P4C

MH Funding

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Steinberg.

He could see the linkage of the problems in Sacramento with the state's failure to honor its earlier commitments to provide community-based care after officials closed mental hospitals.

Steinberg made mental health services a key element of his campaign for the state's Assembly in 1998. He began his service with hopes of passing a $350 million bill to rebuild the state's mental health system but soon confronted political realities that made passage unlikely and developed a more realistic goal.

With the support of John Burton, president pro-tem of the California Senate, and the state's first lady, Sharon Davis, he secured passage of AB 34 in 1999. Initially funded at $10 million, the legislation supported Community Mental Health Demonstration Grants to serve adults with severe mental illness who are homeless or at risk of homelessness.

Steinberg said, "I'm a stickler for accountability. We wanted to make certain the money would be well spent."

The bill required the state's Department of Mental Health to develop a reporting mechanism to conduct "extensive monitoring and evaluation" and report results to the legislature.

Those evaluations helped secure an increase in funding to $55 million in subsequent years and were cited by advocates for Proposition 63 to persuade voters that funds will be well spent.

The CPA has twice named Steinberg Legislator of the Year. The nonpartisan *California Journal* named him Assembly Member of the Year for 2004 and honored him as the Assembly's top member in the categories of integrity, best problem solver, and hardest working.

Steinberg will leave office in 2005 because of term limits. "The number-one thing I want to do," he said, "is to bring this program model to the rest of the country."

Information about AB 34 is posted at <www.dmh.ca.gov/PGRE/Integrated_Services.asp>. ■

Hospitals

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day of the stay for all patients admitted to facilities with a full-service emergency department is included in the rule.

- **Comorbidities:** The number of comorbidities that qualify for a payment increase due to the higher costs of more medically complex patients has been increased.

- **ECT:** An additional payment of $247.96 for ECT services has been included.

- **Age adjustment:** The rule includes eight age-adjustment factors, beginning with groups of patients under 45 and progressing to groups of patients over 80.

- **Rural adjustment:** Psychiatric facilities located in rural areas will receive a 17 percent payment increase.

- **Stop loss:** CMS has developed a stop-loss protection for hospitals that experience extreme losses. The stop loss applies to rural facilities with PPS payments that are less than 70 percent of their original TEFRA payments.

- **Interrupted-stay policy:** CMS has created an interrupted-stay policy that would be applied when a patient is discharged from a facility and returns to the same facility within three consecutive calendar days. In such situations, CMS will treat the two admissions as one and pay accordingly.

Medicare's final rule for prospective payment for inpatient psychiatric facilities is posted online at <www.cms.hhs.gov/providers/ipfpps/cms-1213-f.pdf>. ■

Professional News

Women Outnumber Men Applying To Medical School

For the second consecutive year, women applicants to U.S. medical schools outnumbered men applicants, according to the Association of American Medical Colleges (AAMC). Women made up more than 50 percent of applicants.

The total number of applicants to U.S. medical schools for the 2004-05 school year was 35,727. This figure was 3 percent higher than for the 2003-04 school year.

Entering their first year of medical school this fall were 16,638 students. Of those, slightly less than half—8,229—were women. The class saw an increase in the percentage of black and Hispanic students over last year's entering class: a 2.5 percent increase for blacks and about 8 percent for Hispanics. The number of black students who matriculated in the fall was 1,086 and Hispanic students, 1,174.

Jordan Cohen, M.D., president of the AAMC, which represents all 125 U.S. medical schools, said he was encouraged by the increase in minority enrollees. This was the first admissions cycle since a Supreme Court decision in June 2003 upheld affirmative action in university admissions.

"We interpret [the numbers] to reflect the fact that the decision really clarified the lawfulness and appropriateness of using affirmative action measures," said Cohen in a press release. ■

Association News

Volunteers Needed

APA is seeking volunteers to be a part of its APA Minority Fellowships Program Speakers Bureau. This list is intended to help put APA members in touch with minority experts in various fields willing to speak at allied health organization meetings, grand rounds, and other venues.

Minority members of APA who would like to be added to the list are asked to contact Marilyn King at (703) 907-8653 or mking@psych.org. ■