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Government News

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N.M. Governor Agrees Patient Safety Comes First

APA leaders discuss their concerns about ensuring patient safety as the state develops regulations on psychologist prescribing.

BY JIM ROSACK

APA President Marcia K. Goin, M.D., and Medical Director James H. Scully Jr., M.D., along with Bruce Hinrichs, M.D., president of the Psychiatric Medical Association of New Mexico (PMANM), and George Greer, M.D., PMANM's legislative representative, have secured the support of New Mexico Gov. Bill Richardson for medical board oversight of psychologists' prescribing. He has also agreed to support stringent educational requirements for prescriptive authority.

APA President Marcia Goin, M.D. (left), and Medical Director James Scully, M.D. (far right), meet with N.M. Gov. Bill Richardson (seated), along with Bruce Hinrichs, M.D. (second from left), and George Greer, M.D. (second from right), to discuss implementation of the state's psychologist prescribing law.

Both crucial issues have been debated at length as state regulators have struggled to create a set of rules governing the implementation of the state's Prescriptive Authority to Psychologists Act, which became law in 2002 (*Psychiatric News*, April 5, 2002).

A joint committee of physicians and psychologists has been working to formulate regulations implementing the law, but significant differences on numerous points led to a preliminary report containing both a majority and minority stance (*Psychiatric News*, November 7, 2003).

In essence, the majority recommendations in the report favored weaker oversight of psychologists' prescribing practices and less-stringent educational requirements than did the minority recommendations, which were supported by PMANM.

The December 23, 2003, meeting in the governor's office was scheduled with only three days' notice, as a result of concerns, Hinrichs said, that "several members of the medical board have felt a great deal of pressure from state legislators to resolve the disagreements of the committee by compromising their recommendations for training standards."

Hinrichs told the governor that "such compromise would inevitably loosen the already lax training requirements [in the law] even further." He explained to Richardson (who inherited the implementation of the law from the previous administration) that under the current recommendations, "a prescribing psychologist would be able to write prescriptions with far less training than any other type of prescribing practitioner in the state," creating vital concerns about patients' safety.

please see ***N.M. Governor*** *on page 43*

Government News

Some States Wake Up To Severity Of MH Crisis

The good news is that states are starting to pay attention to the crisis in mental health services. The bad news is that the problems appear to be worsening.

BY KATE MULLIGAN

Problems of access to quality psychiatric care are accelerating for those with serious mental illness, according to recent newspaper accounts, but some states are using the crisis as an impetus for a broad look at their mental health system.

Reporter Jennifer Liberto in the *St. Petersburg Times* (December 7, 2003) told of the plight of indigent persons who are deemed a threat to themselves or others under terms of Florida's Baker Act.

After a suicide attempt, one woman was kept as a boarder at a general hospital, because no psychiatric hospital would take her. If so-called Baker Act patients are first taken to a general hospital for medical treatment, psychiatric hospitals that do not receive state funding are not required to admit them from that hospital. An increasing number of private hospitals in the state have elected not to receive the funding because it does not cover their costs.

The result is that patients are sent to psychiatric hospitals or units at some distance from their homes or are held in general hospitals, which do not have staff to treat them.

Meg Kissinger in the *Milwaukee Journal Sentinel* (December 7, 2003) reported that Milwaukee County had cut the number of beds for patients with acute mental illness by more than half over the past 10 years, "with the notion that private hospitals would care for such patients."

In the last two months, however, one private hospital eliminated its psychiatric ward, and another stopped taking referrals of psychiatric patients who were being detained by the county on an emergency basis. Spokespersons for both institutions said that reimbursement by the government did not cover the costs of care.

James Hill, interim director of behavioral health for Milwaukee County, said that Medicaid covers only a portion of the costs

please see ***MH Crisis*** *on page 43*

The Chrysler and Empire State buildings pierce the night sky above New York City. New York is the host of APA's 2004 annual meeting, which is being held May 1 to 6 at the Jacob K. Javits Convention Center. The meeting's preliminary program and other important information will be published in the next issue of *Psychiatric News*. In the meantime, you can register for the meeting and reserve your hotel room by visiting APA's Web site at <www.psych.org/edu/ann_mtgs/am/04/index.cfm>.

Pioneering Psychiatrist, Psychoanalyst Judd Marmor Dies at Age 93

Judd Marmor, M.D., who died last December, was for much of the 20th century a leading psychoanalyst and educator, but perhaps the most significant part of his legacy is his courageous stand that led the psychiatric community to reject the notion that homosexuality is a mental illness.

BY KEN HAUSMAN

Judd Marmor, M.D., who served as president of APA in 1975-76, died at UCLA Medical Center in Los Angeles on December 16, 2003. He was 93.

Marmor's death came 30 years and one day after APA's Board of Trustees decided to remove homosexuality as a psychiatric disorder from the second edition of the *Diagnostic and Statistical Manual (DSM-II)*, thanks in large part to Marmor's efforts. Insisting that there was no evidence that homosexuality was a mental disorder, Marmor took on the difficult and often unpopular task of spearheading the initiative to depathologize sexual attraction among people of the same gender in the leading compendium of psychiatric diagnoses. The success of this initiative turned Marmor into an enduring hero of the gay-rights movement.

Marmor was a prominent Los Angeles psychoanalyst in the 1960s when he began to challenge publicly his colleagues and APA leaders who maintained that homosexuality was an illness rather than a normal variant of sexual behavior. His opposition to classifying homosexuality as a pathology also challenged the views of Sigmund Freud and most of the other leading psychoanalytic theorists. Marmor had tried for many years to use psychoanalytic techniques with patients who came to him to change their sexual orientation, but he saw that it was a futile endeavor.

He said in the book *Making History: The Struggle for Gay and Lesbian Equal Rights, 1945-1990* by Eric Marcus that he finally realized that "psychoanalysts didn't know enough gay people outside the treatment community who were happy with their lives, who were satisfied and well adjusted. . . . If we made our judgments about the mental health of heterosexuals only from the patients we saw in our office, we'd have to assume that all heterosexuals were mentally disturbed."

For years before APA's 1973 decision, various segments of society routinely turned to APA's declaration that homosexuality was a psychiatric illness to justify discriminating against homosexuals. With the hope that psychiatrists could cure a disorder once they had diagnosed it, families frequently forced members into "treatment" in the hope that their relative would emerge as a heterosexual.

"It would be ironic," Marmor wrote in his APA campaign statement in 1974, "if we ourselves were impairing the lives and adaptive potentials of people by our labeling methods."

Marmor was a prolific author on many topics in psychiatry, psychoanalysis, and human rights, with eight books and more than 350 published papers to his credit. He was a professor of psychiatry at both the University of Southern California and at UCLA. The Dr. Judd Marmor Endowment in Psychiatry at UCLA "supports the acquisition, preservation, and process of library materials in the field of psychiatry" for the university's biomedical library, according to a UCLA catalog.

In addition to serving as APA president, he was president of the Group for the Advancement of Psychiatry and the American Academy of Psychoanalysis.

One of Marmor's students and colleagues, APA President Marcia Goin, M.D., commented that one of his many strengths was that throughout his long career "he remained an independent thinker" despite being a training analyst and "steeped in psychoanalytic theory."

Goin pointed out that Marmor "also championed the advancement of brief psychodynamic psychotherapy, group dynamic psychotherapy, and the integration of psychoanalytic and behavior therapy."

In 1999 Marmor endowed an APA award lecture, the Marmor Award, which honors an individual "who has contributed to research advancing the biopsychosocial aspects of psychiatry." The award comes with a $1,000 honorarium.

Marmor was born in London, England, and spent most of his youth in New York and Chicago. In 1933 he graduated from Columbia University's medical school. He moved to Los Angeles in 1946 after a World War II stint in the U.S. Navy.

Marmor is survived by a son and two grandchildren. His wife died in 1999. ■

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Fellow status is an honor that reflects your dedication to the work of APA and signifies your allegiance to the psychiatric profession. Complete information and application material are posted on the Web at <www.psych.org/members/memcorner/applyfellow.cfm>. Do it today!

When Our Patients Die

BY MARCIA GOIN, M.D.

The newspaper article read: "SWAT officers shoot to death man with a history of mental illness when he 'allegedly' threw a machete at them."

The story is not unique. A young man (whom I will call Joe) with a psychotic disorder stops taking his medication and becomes delusional. He threatens his family and then the police. Although Joe is a small and slightly built man, in the eyes of the SWAT team he appears frightening and dangerous. Of course they can't hear the voices or see the imagined demons that he is trying to fend off with his machete. Fearing for their lives, the SWAT team shoots and kills him.

The newspaper article didn't mention that Joe was being treated in a public clinic by a psychiatrist who was devastated when she heard the news. The psychiatrist had worked with care and skill trying to help Joe accept his illness. She had met with the family, telephoned to encourage him to come in when he missed appointments, and looked for ways to ensure that he took his medication. She knew that Joe would benefit from and be safer with inpatient psychiatric care, but access to hospitalization was not available, so she struggled to make the best of the situation. This psychiatrist, like all of us, now will have to live with the psychological aftermath of a patient's death. This is especially difficult when one feels the death might have been preventable in a world with unfettered access to care.

A patient's death by violence or suicide is psychiatry's nemesis. Several APA practice guidelines remind us that even with the best possible treatment, some patients will still commit suicide. This is small comfort when it is your patient, but such is reality. Similarly, it is also reality that if one works with the seriously mentally ill, the risk of losing a patient in a violent incident is a significant possibility. For other specialists it may be the unstoppable bleed, failed chemotherapy, or a ruptured appendix, but for psychiatrists our medical tragedy is most often a patient's death by suicide or violence.

Every psychiatrist I have known feels stricken when a patient dies by his or her own hand. Do they talk about it? Usually they do not. Often we don't write about it, and we don't discuss it much with colleagues.

Shanafelt and colleagues wrote a thoughtful article on physician grief, titled "When Your Favorite Patient Relapses: Physician Grief and Well-Being in the Practice of Oncology," which appeared in the July 2003 *Journal of Clinical Oncology*. They stated, "[A]lthough much has been written about the grieving process of patients and their families, little is known about physician grief. As a professional caregiver, the physician is expected to be an honest, compassionate, and knowledgeable guide who is able to advise and comfort patents and families in their most desperate hours. But physicians are no less human than others. In fact, many have been drawn to medicine through their sensitivities to the needs and suffering of others."

We are not immune to the reactions of grief and sorrow that affect our patients and their families. Following our initial sense of shock, there may be anger and depression. Reactions may include remorse, guilt, and self-recrimination. Often there is a torrent of "what if" thoughts: "What if I had only done this or that?"

How should we best prepare ourselves and our students for such a cataclysmic event? Psychiatric residents, and particularly those early in their career, are among the most vulnerable. Talking with program directors around the country, I've learned that many include discussion of these issues at various stages of training, beginning with the initial orientation. In the first year there may be monthly group meetings to process whatever tragic events have occurred. Sometimes this becomes an ongoing process extending throughout the four years of residency. Opportunities such as this allow trainees not only to express their reactions openly, but also to experience the helpfulness of colleagues and consultations in the face of devastating clinical experiences. This has an effect on the current situation and on the rest of one's professional career.

Although our primary professional desire is to heal, it is an important part of professional maturity to recognize that there may come a time when no matter how hard we try, the patient's illness will defeat us. That is a time to turn to our colleagues, consultants, and ourselves to appreciate the natural effect this will have on our own inner lives. ■

Stewart Elected Foundation President

Altha J. Stewart, M.D., has been elected president of the American Psychiatric Foundation. Her term began January 1. She succeeds Abram M. Hostetter, M.D., who retired from the foundation's board at the end of 2003 after five years as president.

Stewart, who is a psychiatric consultant and educator in Memphis, Tenn., has served on the board of the foundation since 2000. She is chair of the APA Council on Social Issues and Public Psychiatry.

"I am honored to have the opportunity to serve as the president of the foundation," said Stewart. "I hope to continue the foundation's focus on patients and families through programs that encourage early intervention and increase access to care."

Five others were also appointed to three-year terms on the foundation's Board of Directors. They are Robert Gould, Ph.D., Richard Harding, M.D., R. Michael Pearce, M.D., Laurie Garduque, Ph.D., and Linda Sutton.

The American Psychiatric Foundation is a charitable and educational subsidiary of APA focused on raising awareness of mental illness and increasing access to quality care.

More information on the foundation is posted online at <www.PsychFoundation.org>. ■

Major Suit Against Insurers Heads to Next Phase

Physicians and state medical associations that have sued several health insurers will have their day in court in September. A federal judge's decision last December in the landmark case was a blow to the health plans that have fought to have the case dismissed.

BY CHRISTINE LEHMANN

A class-action lawsuit brought by 15 medical associations and more than 700,000 physicians against major health insurers will go to trial in September, according to presiding Judge Federico Moreno of the U.S. District Court in the Southern District of Florida, Miami Division.

The defendants named in *In re: Humana Inc. Managed Care Litigation*, which was filed in Miami in 2000, were Aetna, Anthem Blue Cross, Cigna Corporation, Coventry Health Care, Humana Health Plan, Pacifica Health Systems, United Health Group, and Well Point Health Networks. Cigna and Aetna are no longer part of the lawsuit, having settled last year with the plaintiffs for $540 million and $470 million, respectively *(Psychiatric News*, October 3, 2003; November 7, 2003).

The class of physicians consists of those who provided medical services insured by any defendant between August 4, 1990, and September 30, 2002.

The lawsuit alleges that the health insurance companies violated the federal Racketeer Influenced and Corrupt Organization (RICO) Act by unfairly denying or delaying payments for medical care. Specific allegations are that the companies "covertly manipulate, maneuver, and exploit long-standing accepted industrywide practices for financial gain, capitation payment schedules are founded on actuarially unsound principles and are manipulated by defendants to increase their profits at the expense of the physicians who provide medical services, [companies] systematically deny and delay payments due physicians and profit from the moneys wrongfully retained" (*Psychiatric News*, May 3, 2002; October 18, 2002).

Similar charges were filed by state medical associations against Blue Cross in a separate lawsuit in September. Last month the North Carolina Medical Society filed a similar lawsuit against the state's Blue Cross and Blue Shield organization (see story below).

Leaders of state medical associations who joined the landmark lawsuit welcomed Moreno's decision to proceed to trial.

Jack Lewin, M.D., CEO of the California Medical Association, remarked in a news release, "Judge Moreno's order is very encouraging for all of America's physicians. This case represents the beginning of a new and positive relationship between physicians and the nation's health plans."

John Allen, M.D., president-elect of the Texas Medical Association, remarked in the release, "This ruling confirms the entire basis on which this landmark case is founded. We look forward to moving ahead on behalf of our patients to correct the abuses of the managed care industry."

Archie Lamb, co-lead counsel for the physicians, said in the release, "This ruling underscores the legitimacy of the physicians' claims despite the industry's attempt to stop the case from the beginning. The team of over 200 attorneys who represent the 700,000 physicians have been preparing to take this case to court."

Moreno will now have to rule on an appeal by the defendants to break up the class-action lawsuit and settle a dispute over the trial's location, according to a January 7 article in *Modern Physician*.

Moreno plans to ask a national panel of judges to decide whether he should remain in charge of the case after three years of pretrial supervision, according to the article.

More information about the lawsuit is posted on the Web site of the California Medical Association at <www.cmanet.org> and on a Web site by Lamb at <www.hmocrisis.com>. ■

Medical Society Charges Blues With Unfair Reimbursement Practices

Blue Cross/Blue Shield of North Carolina was sued by the state medical society on charges that it engaged in deceptive and unfair business practices that harmed physician income.

BY CHRISTINE LEHMANN

The courts will decide whether Blue Cross/Blue Shield of North Carolina (BCBSNC) has shortchanged physicians in a new lawsuit filed by the North Carolina Medical Society last month.

"BCBSNC has engaged in numerous unfair and deceptive acts and practices designed to delay, deny, impede, and reduce lawful reimbursement to NCMS physicians who are participating in its networks," according to a summary of the complaint, which was filed in Wake County Superior Court.

For example, BCBSNC uses software programs that "automatically downcode procedures and/or deny payment to physicians without appropriate clinical review, oversight, or justification," according to the complaint.

The medical society also complained that physicians can no longer "obtain a coverage decision from BCBSNC prior to rendering a service" because the insurer ended its predetermination program.

In addition, the insurer "failed to provide adequate staffing, staff training, or staff supervision to handle physician inquiries."

Similar charges were brought by 15 medical societies in a national lawsuit against several large health care insurers including Anthem Blue Cross/Blue Shield (see article above). Although both the state and national lawsuits are seeking significant changes to the insurers' business practices, NCMS isn't seeking financial relief for its members.

NCMS had met with BCBSNC and other managed care organizations for several years to discuss these and other concerns identified by NCMS physician members, said society president Lawrence Cutchin, M.D., in a statement.

The talks broke down last year after NCMS refused to sign a confidentiality agreement that BCBSNC requested to protect its position in another national lawsuit. BCBSNC and 64 other Blue Cross affiliates and the national BC/BS Association are defendants in a lawsuit filed by physicians last August in the Southern District Court of Florida, according to the statement.

NCMS has retained the New York law firm Milberg Weiss, which "successfully represented us in the settlement talks with Aetna US Healthcare and Cigna Healthcare," said Cutchin in the statement. The two companies settled for $470 million and $540 million, respectively, last year.

Information about the lawsuit is posted on the NCMS Web site at <www.ncmedsoc.org/> under "News Highlights" and "North Carolina Medical Society Files Lawsuit Against Blue Cross." ■

Landmark Suit Arrives At Long-Awaited End

It has been 33 years since a federal judge said care in Alabama's psychiatric hospitals was so poor it violated patients' constitutional rights. After decades of failing to do so, the state has finally improved care sufficiently.

BY KEN HAUSMAN

It took more than three decades, but the curtain has finally come down on a lawsuit filed in 1970 to guarantee that patients involuntarily committed to psychiatric hospitals have a right to adequate treatment in return for being confined against their will.

The case, *Wyatt v. Sawyer*, was filed as *Wyatt v. Stickney* 33 years ago as a class action on behalf of Ricky Wyatt, who had been civilly committed to Bryce Hospital, a state psychiatric facility in Tuscaloosa, Ala. (Stonewall B. Stickney was Alabama's mental health commissioner at the time the suit was filed.)

Lawyers and mental health advocates were determined to improve the sorry state of what passed for treatment in the late 1960s in Alabama's state-run psychiatric hospitals. The state had cut staffing levels and programs at Bryce and other hospitals to compensate for funds lost after the Alabama legislature slashed the state's cigarette tax. Once the cuts were enacted, only one psychiatrist was left to treat Bryce's 5,000 patients, and 50 cents a day was budgeted for each patient's food. The physical plant was allowed to deteriorate severely, and advocates documented dirty and overcrowded conditions.

The advocates who initiated the lawsuit thought that a victory celebration was in order in 1972, when Federal District Court Judge Frank Johnson decided the case in favor of Wyatt and the class of plaintiffs.

Johnson ruled that involuntarily committed patients have a constitutional right to adequate treatment that might cure or improve their condition and that the judicial system has the right to intervene when a state fails to meet minimum standards for psychiatric care.

"To deprive any citizen of his or her liberty upon the altruistic theory that confinement is for humane and therapeutic reasons," Johnson declared in his landmark ruling, "and then fail to provide adequate treatment violates the very fundamentals of due process."

In the years following the decision, however, Alabama officials failed to improve hospital conditions in accord with the standards that Johnson had identified if the state was to meet its constitutional obligation to patients confined in its psychiatric facilities.

Johnson left very little to chance or to the mutable preferences of state health officials. He detailed standards for the psychiatric hospitals that governed such concerns as staffing ratios, development of treatment plans, nutritional requirements, and a least-restrictive-alternative standard. The judge went so far as to mandate a minimum number of toilets available to patients and the frequency with which staff had to change bed linens.

He gave the state six months to bring its psychiatric hospitals in line with the standards he laid out.

In Alabama, however, a series of governors, other state officials, and state lawmakers repeatedly failed to take the steps necessary to comply with Johnson's requirements, including allocating sufficient funds to carry out his orders.

By 1977 the very frustrated plaintiffs went back to federal court, where they suc-

please see ***Landmark Suit*** *on page 44*

Repeated Ecstasy Warnings Drive Down Use of Drug

Media campaigns warning teens about the perils of drug use continue to drive drug usage rates down, according to an annual survey by researchers at the University of Michigan.

BY EVE BENDER

In light of widespread media accounts about the severe consequences of Ecstasy use, an increasing number of U.S. teens are thinking twice about experimenting with the drug. In fact, peak usage rates dropped as much as 50 percent since 2001 among 10th and 12th graders, according to the results from the 2003 Monitoring the Future Survey.

The findings from the annual survey were released at a press conference in December in Washington, D.C.

Researchers began conducting the survey in 1975 to measure self-reported drug, alcohol, and cigarette use among teens.

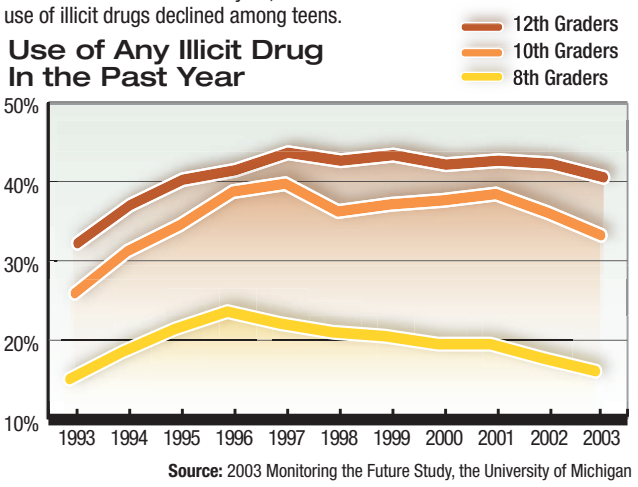
To obtain the latest data, which assess drug use in the previous calendar year and in the month preceding the survey, researchers from the University of Michigan's Institute for Social Research interviewed approximately 17,000 eighth graders, 16,200 10th graders, and 15,200 seniors, for a total of 48,400 students in 392 U.S. high schools.

Survey results showed that the percentage of the students reporting Ecstasy use in the 2003 survey dropped by nearly half since 2001.

Ecstasy use among 10th and 12th graders rose gradually from 1998 until 2001, when 6.2 percent of 10th graders and 9.2 percent of 12th graders reported using the drug. By the 2003 survey, just 3 percent of 10th graders and 4.5 percent of 12th graders reported using the drug in the past year.

Teen Drug Use Down, Again

For the second consecutive year, use of illicit drugs declined among teens.



Source: 2003 Monitoring the Future Study, the University of Michigan

The study's principal investigator, Lloyd Johnston, Ph.D., attributed the decrease to a growing realization by teens that the drug is dangerous. "It now appears that teens are finally getting the word about Ecstasy's potential consequences, probably due to the extensive media coverage of the issue and concerted efforts by several organizations active in educating young people about the dangers of Ecstasy," he said in a press release from the U.S. Department of Health and Human Services.

> "This survey shows that when we push back against the drug problem, it gets smaller."

John P. Walters, director of the White House Office of National Drug Control Policy, credited drug-prevention campaigns such as the National Youth Anti-Drug Media Campaign for helping to alert adolescents to the dangers of drug use. "This survey shows that when we push back against the drug problem, it gets smaller," Walters said in the December press release

Researchers found an overall decrease in any illicit drug use for all three grades over the past two years—from 19.4 percent in the 2001 survey to 17.3 percent in 2003, which translates into 400,000 fewer teen drug users.

The latest survey found that other forms of drug use also dropped:

- Marijuana and hashish use declined for the second consecutive year for high school students and for the seventh consecutive year for eighth graders. About 13 percent of eighth graders surveyed reported using one or both, down from 15.4 percent in 2001. Tenth graders' use dropped from 32.7 percent in 2001 to 28.2 percent in 2002. Marijuana use among seniors dropped only from 36 percent to 35 percent during that time.
- LSD use has been declining in all three grades since 1996, but drops have been the greatest over the last two years. In 2001, 6.6 percent of seniors reported using LSD during the previous year, compared with 1.9 percent in 2002.
- Smaller decreases were noted for 10th and 12th graders who reported using amphetamines (almost 11 percent of 10th graders used amphetamines in 2001, compared with 9 percent last year) and tranquilizers (7.7 percent of seniors used the drug in 2002 compared with 6.7 percent in 2003).

please see ***Teen Drug Use*** *on page 44*

CMHC: Dream Deferred But Still Worthwhile

Psychiatrists find enduring strengths in a vision for mental health services that motivated reformers 40 years ago.

BY KATE MULLIGAN

The concept of community mental health centers (CMHCs) once symbolized the hope that a person with mental illness of any income level could live and be treated effectively in communities.

Now, more than 40 years later, those centers often are regarded as "hostile territory" by psychiatrists, according to APA's immediate past president, Paul Appelbaum, M.D., because many centers underwent a process of "demedicalization" that minimized the importance of psychiatric leadership.

Yet, he and other psychiatrists think that the CMHC model itself offers promise to those searching for ways to address problems of fragmentation and lack of access to mental health services.

Appelbaum told a Senate subcommittee hearing on substance abuse and mental health services, "It was a terrific concept" *(Psychiatric News*, December 5, 2003).

He joined three other APA members in a conversation with *Psychiatric News* about what should be retained from the CMHC movement and what mistakes should be avoided.

Michael Engel, D.O., directed two CMHCs and is in private practice. As president of the Michigan Psychiatric Society, he recently testified before the state legislature about the importance of restoring a medical model to CMHCs *(Psychiatric News*, November 17, 2003).

APA Vice President Steven Sharfstein, M.D., was director of the Division of Mental Health Services Programs at the National Institute of Mental Health (NIMH) when CMHC legislation was being developed, and he co-wrote a book, *Madness and Government* (APPI, 1983), about that process and some of its outcomes.

Altha Stewart, M.D., was director of the largest CMHC in Michigan, the Detroit-Wayne County Community Mental Health Agency, from 1999 to 2002 and has extensive experience in community psychiatry, managing large public systems in New York City and Philadelphia over the last decade.

Two core ideas about CMHCs "retain their vitality," said Appelbaum. The first is catchment area, which means that a CMHC is responsible for the mental health of people who live in a defined area.

That clear allocation of responsibility meant that center staff "had every incentive to go out into the community to do early intervention and to encourage prompt use of services instead of waiting for people to come to the clinic or discouraging such use."

Single point of access is the second idea.

"If people needed help, they knew where to go, even if they didn't have a private doctor. CMHCs offered a spectrum of services that allowed a single treatment team to retain responsibility for care as a patient's needs change. Accessing mental health services is incredibly difficult for people today."

Stewart pointed out that CMHCs also offered "fertile ground for people entering the profession to learn a range of dimensions of psychiatry."

She and others were able to gain experience with the continuum of care associated with CMHCs and to learn how to work effectively in the community.

"The quality of our workforce is affected when opportunities for those training opportunities diminish," she said.

Those in training were able to experience an integration of disciplines, said Engel. "In some cases, the centers also became a place for the development of subspecialty expertise in the treatment of serious and persistent mental illness."

Most CMHCs, however, have not lived up to the hopes of their advocates. (See article below for brief history.) Money, and the methods by which it was allocated, was a key factor.

Advocates were able to get federal support only for construction costs of CMHCs in the first piece of legislation.

To secure funds for staffing, they compromised and agreed to a seven-year period of decelerating federal support for staff. The hope that state governments and other funding sources, such as unions, would fill the gaps at the end of that period was not fully realized.

"Instead," Sharfstein said, "centers frequently had to rely on fee-for-service payment in the form of Medicaid and some limited private pay."

That shift, in turn, led to other negative consequences. Reimbursement was not available for the kinds of services and activities—such as outreach, prevention, and interdisciplinary team development—that could have ensured the long-term success of the model.

In 1971 psychiatrists directed 55 percent of the CMHCs; by 1977, the figure was 26 percent.

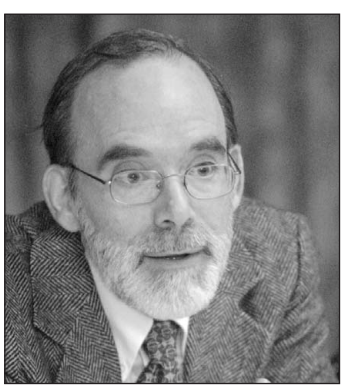
Cost was one reason for the shift away from a reliance on psychiatric leadership, said Sharfstein. With declining resources, CMHCs turned to "less expensive" administrative staff and encouraged psychiatrists to spend their time on activities, such as medication management, that provided good reimbursement to the centers.

Larger societal forces also affected the CMHCs.

Stewart said, "The planners never fully appreciated the severity of co-occurring disorders. They thought of people as being mentally ill and didn't realize the same population also had a high incidence of sub-

please see ***CMHCs*** *on page 34*

Michael Engel, D.O.: "We need a new approach in which psychiatrists deliver care in primary care settings."



Paul Appelbaum,M.D.: "If people needed help, they knew where to go, even if they didn't have a private doctor."

Steven Sharfstein, M.D.: "CMHCs were a concrete expression of the right of every American to quality mental health care."

Altha Stewart, M.D.: "CMHCs offered fertile ground for people entering the profession to learn a range of dimensions of psychiatry."

Battles Over Money, Mission Limited CMHCs' Success

Presidential priorities, deinstitutionalization, and attitudes toward the federal government are among the factors that sapped the strength of the community mental health center movement.

BY KATE MULLIGAN

The concept of community mental health centers (CMHCs) has been an important part of discussions about how to provide mental health services at least since 1960, when the federal Joint Commission on Mental Illness and Health proposed one "fully staffed, full-time mental health clinic" for each 50,000 of population.

In that year, the Democratic Party voted at its convention in favor of a plank in support of "greatly increased federal support for psychiatric research and training and community mental health programs to [help hospitalized mentally ill live in communities]."

President John F. Kennedy attempted to fulfill that campaign promise with the appointment of a National Institute of Mental Health (NIMH) study group, which recommended "comprehensive" CMHCs offering inpatient, outpatient, and rehabilitative services, as well as education and public information.

A coalition of mental health organizations supported a Kennedy proposal for CMHCs that would have provided funding for construction of CMHCs and limited staffing grants.

Congress approved the construction costs but not the staffing grants until President Lyndon B. Johnson requested them with legislation, the Community Mental Health Centers Act Amendments, which passed in 1965.

The NIMH mandated that CMHCs were to provide five essential mental health services: inpatient, emergency, partial hospitalization, outpatient, and education.

Henry Foley, Ph.D., and Steven Sharfstein, M.D., wrote in *Madness and Government* (APPI, 1983), "In the beginning, then, CMHC services plus those of the state hospitals theoretically represented a balanced array, but the CMHC program alone did not. . . . The unanticipated consequence. . .was the failure of most CMHCs to develop even minimal rehabilitation and aftercare services for the mentally ill being discharged or diverted from state hospitals."

In 1972 President Richard M. Nixon argued that federal support for the CMHC program should be phased out and replaced with local support.

Instead, in 1975 with new legislation, seven new services were added to the definition of "essential service."

"The enactment of PL 94-63 in July 1975 over a presidential veto climaxed a seven-year struggle for program survival, which included appropriation battles and impoundment suits," wrote Foley and Sharfstein.

By 1977, 650 CMHCs had been funded, covering 43 percent of the population and serving 1.9 million people that year. The $1.5 billion federal investment generated another $2.5 billion in other sources of funds.

In 1977, however, the average length of stay for a patient in a state hospital was three weeks, down from six months in 1955.

"The bold new CMHC approach had little time and too meager resources to test its mettle before being overtaken. . .by the urgent needs of patients with chronic mental illness," wrote Foley and Sharfstein. In 1977, President Jimmy Carter established the President's Commission on Mental Health, which ultimately made more than 100 major recommendations and findings.

After considerable debate within the administration, Carter submitted the Mental Health Systems Act to Congress in 1979, where it was subjected again to much debate.

"The primary mission of community mental health has been disputed since the beginning: the Systems Act forcefully restated each of three missions without resolving priorities," according to Foley and Sharfstein.

The missions are adequate clinical care, particularly for those with serious mental illness; supportive services; and prevention.

President Ronald Reagan, who was elected in 1980, recommended that Congress cut the level of funding for the act by 25 percent and convert it into a block-grant program.

In August 1981 he signed the Omnibus Budget Reconciliation Act, which "substantially repealed the Mental Health Services Act. . . . The federal government was entirely removed from the direction of the program and became a mere conduit of funds to the states." ■

Exhibit Honors Women M.D.s Who Made a Difference

The interactive exhibit "Changing the Face of Medicine" is a virtual "who's who" of women in medicine. Included in the exhibit are a number of outstanding women psychiatrists who have advanced the field of mental health.

BY EVE BENDER

More than 20 women psychiatrists, including several who have been active in APA leadership over the years, are included in a new exhibit celebrating the accomplishments of women physicians at the National Library of Medicine in Bethesda, Md.

The exhibit, "Changing the Face of Medicine," blends the old with the new: there are artifacts such as the uniform worn by Mary Walker, M.D., a civil war surgeon; the notes of Elizabeth Blackwell, M.D., the first woman to receive a medical degree from an American college; and antique microscopes.

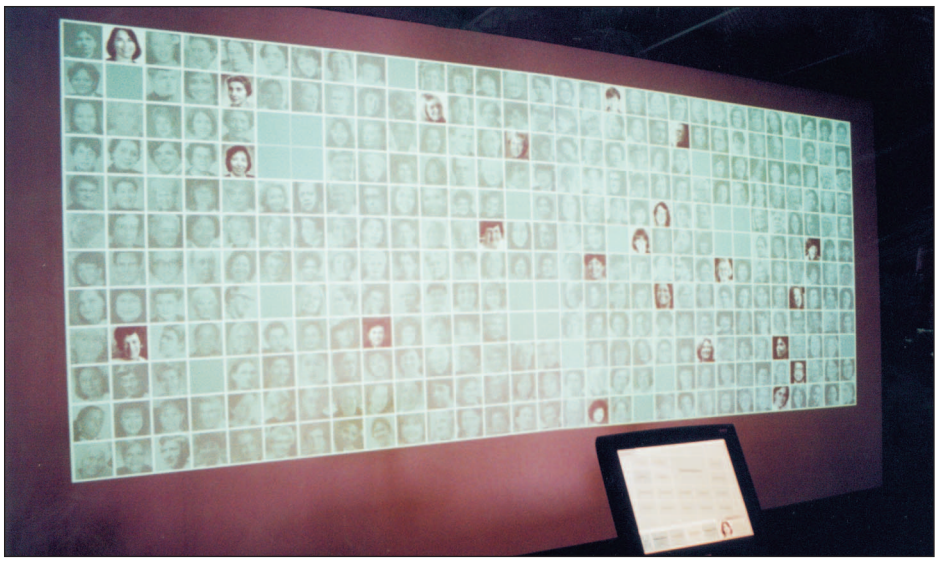
Computer technology brings a modern, interactive element to the exhibit. Visitors can learn more about the histories and achievements of the 339 women physicians in the exhibit by approaching a "digital gallery" toward the front of the exhibit and searching the physician database on one of the several computers available. It's possible to search by physician name, specialty, or geographic location, for instance. The image and biographical information of each selected physician appear on a large screen in front of the computers.

There are also kiosks with computers throughout the exhibit that provide historical information and videotaped interviews with some of the women physicians featured in the exhibit.

All of the images and information found in the library's exhibit can also be found on a companion Web site.

Visitors to the exhibit will learn about the struggles and triumphs of women psychiatrists of various ages, ethnic backgrounds, and professional interests (see box). Each has furthered the field of psychiatry in some significant way.

Jeanne Spurlock, M.D., who died in 1999, is noted as being the first African American and the first woman to receive the Edward



The interactive exhibit of women physicians, "Changing the Face of Medicine," at the Library of Medicine in Bethesda, Md., includes a digital portrait gallery that allows visitors to select physicians by various factors, such as specialty, for viewing purposes. Above are the faces of the psychiatrists featured in the exhibit.

Celebrated Women

The following women psychiatrists are featured in the National Library of Medicine's interactive exhibit "Changing the Face of Medicine":

- Jill Nina Newman Afrin, M.D.
- Linda S. Austin, M.D.
- Grete Lehner Bibring, M.D.
- Susan Jane Blumenthal, M.D., M.P.A.
- U. Diane Buckingham, M.D.
- Raquel Eidelnan Cohen, M.D.
- Leah J. Dickstein, M.D.
- Mary Jane England, M.D.
- Helen Hofsommer Glaser, M.D.
- Jimmie C. Holland, M.D.
- Christie Ann Huddleston, M.D.
- Lissy Feingold Jarvik, M.D., Ph.D.
- Catharine Gail Kincaid, M.D.
- Elisabeth Kübler-Ross, M.D.
- Margaret Morgan Lawrence, M.D., M.P.H.
- Shirley Faye Marks, M.D., M.P.H.
- Martha Alicia Medrano, M.D., M. P. H.
- Jean Baker Miller, M.D.
- Carol Cooperman Nadelson, M.D.
- Joan Y. Reede, M.D., M.P.H.
- Carolyn B. Robinowitz, M.D.
- Mary Hasbah Roessel, M.D.
- Jeanne M. Spurlock, M.D.
- Rebekah May Wang-Cheng, M.D.
- Norma Spielman Wohl, M.D.

A. Strecker, M.D., Award from the Institute of the Pennsylvania Hospital for excellence in psychiatric care and treatment.

Spurlock was deputy medical director of APA's Office of Minority and National Affairs from 1974 to 1991 and a pioneering advocate for children and minorities.

According to the exhibit's biography, Spurlock "made significant contributions in focusing the medical community's attention on the stresses of poverty, sexism, racism, and discrimination. . . ."

After her death, APA created the Jeanne Spurlock Congressional Fellowship, which provides general psychiatry and child psychiatry residents an opportunity to work in a congressional office or for a committee on federal health policy, especially on issues related to children and minorities.

In 2000 APA established the Jeanne Spurlock, M.D., Minority Fellowship Program Achievement Award, which acknowledges the achievements of former fellows who have made significant contributions to the profession and/or the minority community.

Working With the Deaf

Jill Afrin, M.D., is believed to be the first psychiatrist who was trained to work with deaf patients in South Carolina, according to the exhibit. She is also noted as being the first telepsychiatrist in that state.

Through the South Carolina Department of Mental Health's Deaf Services Program, Afrin held therapy sessions with deaf patients with mental illness across the state beginning in the mid-1990s.

At first, she spent the majority of her time crisscrossing South Carolina in her car to treat the patients. When she decided to start a family, the hectic commuting schedule became a problem. So the department installed videoconferencing equipment in Afrin's home and in six hospitals and 14 health centers around the state, which helped her to communicate with increasing numbers of patients using sign language.

According to Afrin's biography, having a home office also allowed her to be "available for both my family and career."

The only drawback of working with patients on a videoconferencing system, she said, was that she missed "being able to see them in their environment" or having "the ability to hand them a tissue."

For this reason, in 1999 Afrin returned to traveling as a staff psychiatrist for a limited number of South Carolina mental health centers.

Balancing Career and Family

The exhibit recognizes Leah Dickstein, M.D., as a physician who helped others learn how to balance family and career while focusing on individual well-being

please see ***Women*** *on page 37*

One part of the exhibit focuses on Leah Dickstein, M.D., a professor of psychiatry at the University of Louisville School of Medicine and an associate dean for faculty and student advocacy. Dickstein was cited for her work in teaching medical students and residents about the importance of balancing family and career while focusing on individual well-being.

A Few Simple Steps Can Avert Medical Errors

Most malpractice lawsuits against psychiatrists stem from medication errors. An attorney who specializes in this area explains how psychiatrists can help ensure patient safety.

BY CHARLES CASH, J.D., LL.M.

This article is part of a series on what psychiatrists can do to ensure they are practicing in a safety-conscious manner.

Psychoactive medications have become the centerpiece for psychiatrists in the treatment of mental illness. Prescribing medications is such a routine activity that it is easy to lose sight of basic risk management strategies that can help improve patient care and minimize medication-related adverse events.

Most lawsuits against psychiatrists include allegations involving medications, and many of those lawsuits involve preventable medication events. APA and other national organizations have undertaken sweeping efforts to raise awareness of and reduce adverse medication events and, thereby, increase patient safety.

APA's Committee on Patient Safety has taken the lead in such initiatives for psychiatry. ("The APA Task Force on Patient Safety: Recommendations to the APA Board of Trustees" is posted online at <www.psych.org/pract_of_psych/apa_patientsafety_toc21003.pdf>.)

The five steps of the risk management process can help improve patient safety. This process is applied here to identifying, analyzing, and minimizing preventable adverse medication events.

Step 1: Identify Current and Potential Risks

Data from psychiatric malpractice lawsuits reveal that adverse medication events are a frequent identifiable cause of lawsuits. Even when a medication-related event is not the basis for the lawsuit, some form of medication misadventure often appears in the facts of the case. A review of cases and risk management consultations handled recently by Professional Risk Management Services Inc., manager of the APA-endorsed Psychiatrists' Professional Liability Insurance Program, found the following areas of risk related to adverse medication events:

- Lack of adequate patient assessment
- Failure to obtain and/or monitor laboratory test results
- Failure to address multiple positive toxicology screens for drugs of abuse
- Changing medications without consulting with or notifying other treating physicians
- Rapidly starting and stopping antipsychotic medications or making large dosage adjustments resulting in neuroleptic malignant syndrome
- Polypharmacy that increased adverse interactions
- Issues with complimentary/alternative medicines
- Written errors and altered or forged prescriptions

Step 2: Evaluate Risks (Frequency and Severity)

Adverse medication events are a high frequency/high severity risk, according to information from psychiatric malpractice lawsuits. Medication misadventures appear in half or more of the psychiatric malpractice suits reviewed for this article.

Step 3: Choose a Risk Management Strategy

Easily implemented risk-reduction strategies should be immediately targeted where they will have the most impact.

• *Assess patients and monitor laboratory test results:* Put in place a process for obtaining and documenting appropriate baseline laboratory testing and for making sure that follow-up testing is completed and reviewed. Obtain a comprehensive patient history and any necessary examinations before prescribing medications. See patients at clinically appropriate intervals.

• *Assess patients for substance abuse issues:* Remain aware of the potential for misuse and abuse of medications. Make appropriate treatment assessments and referrals for addiction and dependence issues. Be aware that patients might be altering prescriptions or "doctor shopping." Document the dosage and size of all prescriptions and the frequency of prescription-renewal requests in an easily accessible format.

• *Communicate with the patient:* Educate patients about medication instructions, including the dose and frequency, ways to identify side effects, and what to do in the event of side effects or a bad reaction. Inquire about other medications the patient takes. Remind the patient to report any changes in medications or any new medications prescribed by another physician, including over-the-counter medications, herbal remedies, dietary supplements, and other treatments the patient uses. Regularly discuss with patients their compliance with the given instructions.

please see ***Medical Errors*** *on page 34*

Charles Cash, J.D., LL.M., is a senior risk manager at Professional Risk Management Services Inc., manager of the APA-endorsed Psychiatrists' Professional Liability Insurance Program.

Candidates Can't Avoid Issue Of Health Care Costs

Republicans and Democrats agree on one point: fears about rising health care costs will be reflected at the ballot box.

BY KATE MULLIGAN

Voters view issues today through the lens of economic uncertainty, according to polling results from Lake, Snell, Perry (LSP) reported at an Alliance for Health Reform meeting last October.

LSP President Celinda Lake told the audience, "Health care is the number one economic concern."

The Alliance for Health Reform is a nonpartisan, nonprofit group that provides information about the nation's health care problems to elected officials and their staffs, policy analysts, advocates, and others. LSP is a political research firm that conducts polls and analyzes issues for Democratic candidates.

In response to the question, "Thinking specifically about the economy, what are you personally worried about the most?," 35 percent of a national poll of 1,000 likely voters last September said "rising health care costs" was their top concern.

The next highest ranking went to "higher taxes," at 18 percent.

There is a new group of voters, Lake said, whom she called the "anxious insured." They are worried about losing their jobs and health benefits and about catastrophic medical expenses.

Lake advised that these messages are likely to persuade voters.

- Health care costs are out of control. We need affordable health care.
- Our proposals will reduce health care costs for working families.
- Thousands of working people and children in our community have no health coverage, and more are losing coverage every day.

She said that there is "enormous energy" about the costs of prescription drugs, which is reflected in the support for reimportation of drugs from Canada and for proposals that the federal government "use its clout" to negotiate prices with pharmaceutical companies. Currently, the federal government negotiates prices with those companies for patients served by the Department of Veterans Affairs and requires rebates for Medicaid patients.

Bill McInturff, a partner in Public Opinion Strategies, which advises Republican candidates, agreed with Lake about the importance of health care issues to voters. He said that Republicans are "really now entranced and impacted by the health care issue," because supporters from corporations and small businesses "are telling them this [cost] is out of control."

McInturff believes that the conditions are right for a major debate about health care. There is a "confluence of high cost, unstable private insurance market, concern about their own care, and what they [voters] perceive to be a weakened economy."

There was a major debate when those same conditions converged in the early 1990s, but he believes that "it was judged by the American electorate that [President Bill] Clinton went too far, and since then we've had microdebates."

He argued that Howard Dean and then-candidate Richard Gephardt would be vulnerable because of their proposals to roll back tax cuts. Voters, according to McInturff, frequently tell pollsters they are willing to have taxes raised for additional benefits, but do not act on those views in an election.

"Healthcare as a Campaign Issue: A Winner in 2004?" is posted online at <www.kaisernetwork.org/health_cast/uploaded_files/102003_alliance_elections_t1.pdf>. ■

Suit Targets PBM's Relationship To Drug Firms

BY KATE MULLIGAN

Two New York labor unions are suing Express Scripts Inc., a pharmacy benefits management (PBM) company, charging the company with receiving kickbacks from drug manufacturers to recommend higher-priced drugs and with keeping rebates instead of passing them back to health plans.

The suit, which was reported by the Associated Press in the January 12 *SunSentinel.com*, the Web site of the *South Florida Sun Sentinel*, was filed December 31, 2003, in the state Supreme Court in New York City by the Organization of New York State Management/Confidential Employees and United University Professions, which represent state workers.

Steve Littlejohn, spokesperson for Express Scripts, is reported to have declined to comment on the suit but to have noted that the company has complied with the terms of its contract by providing lower-cost prescription drugs to its members.

In March 2003 the Prescription Access Litigation (PAL) project and the American Federation of State, County, and Municipal Employees filed suit against four PBMs, including Express Scripts. They charged "fraudulent conduct" because the defendants allegedly "prevented government-funded or -maintained health plans and consumers from knowing what the actual rebates, spread, and other payments were" *(Psychiatric News*, April 18, 2003).

At the time a spokesperson for Express Scripts said, "Express Scripts enables each client receiving rebate (manufacturer discount) revenue to audit its rebate revenue. . . . [The company] has been phasing out manufacturer funding for drug-specific education programs. . . . [T]he payments will be completely phased out by October 1, 2003."

A PAL spokesperson said that the March suit was at the "pretrial motion" stage.

"Drug Manager Sued Over Rebates, Prices" is posted at <www.sun-sentinel.com/news/nationworld/ats-ap_health13jan12,0,672958.story?coll=sns-apt>. ■

Autism Research to Receive Large Funding Increase

The Centers for Disease Control and Prevention partners with the Autism Society of America to develop a new national autism awareness and screening program.

BY CHRISTINE LEHMANN

Funding for autism-related activities at the Centers for Disease Control and Prevention (CDC) is expected to increase significantly in the next year, now that the House of Representatives has approved a conference report containing the Fiscal 2004 appropriations for the Department of Health and Human Services (HHS) and several other federal departments. HHS oversees the CDC and the National Institutes of Health, among other national health-related agencies.

The HHS measure is expected to remain unchanged when the Senate votes on the conference report this month, according to APA's Division of Government Relations.

The House conference report, which is a compromise between seven House and Senate Fiscal 2004 appropriations bills, allocates $5.2 million to the CDC to expand its autism-related activities. This is $3 million above what Congress approved for this purpose last fiscal year.

The congressional conferees designated $3 million of the total amount for the CDC to expand its capacity to identify diagnosed cases of autism so that it can monitor any changes in incidence of the disorder.

The remaining $2.2 million is for the CDC to establish a national education program to help families recognize and health care professionals diagnose autism, according to the conference report. A provision states that the CDC must administer and pilot the program in partnership with voluntary, nonprofit autism organizations.

The Autism Society of America (ASA) has been working closely with members of Congress and the CDC to expand monitoring of autism cases, raise awareness of the importance of early diagnosis of the disorder, and support autism research, ASA President Rob Beck said at a national summit on autism in November 2003 (see story on page 27).

Beck announced that the ASA has partnered with the National Center on Birth Defects and Developmental Disabilities at the CDC and with the American Academy of Pediatrics to develop an early screening and protection program focused on autism.

The program's goal is to screen children early so they can begin treatment. "Most children are not diagnosed with autism disorders until [they are of] school age, and years of treatment have been lost," said Beck.

The new national program will focus first on educating parents about how to recognize autism and other potential disabilities. Approximately 40 percent of people diagnosed with autism have another disability, Beck noted.

Pediatricians and their staffs will be educated about best diagnostic practices, because many have indicated that they feel unprepared to assess a child's developmental status, said Beck.

Information about the national autism education and screening program is posted on the ASA Web site at <www.autism-society.org/site/PageServer>. ■

New Help Line for Dual Diagnoses

The Substance Abuse and Mental Health Services Administration announced last month the creation of a technical assistance center and help line to support state efforts to provide effective treatment services for persons with co-occurring substance abuse and other mental disorders.

The center, called the Co-Occurring Center for Excellence, will help identify best practices in treating individuals with dual diagnoses and will support the application of these practices through technical assistance and cross-training, state-of-the-art materials, and a Web site.

Assistance will be available to all states and to substance abuse, mental health, criminal justice, education, and other social and public health systems seeking to enhance their ability to serve individuals with co-occurring disorders.

Requests for technical assistance must be made in writing and sent by mail to Jill Hensley, Project Director, Co-Occurring Center for Excellence, 5530 Wisconsin Avenue, Suite 1600, Chevy Chase, Md. 20815, or by e-mail to samhsacoce@cdmgroup.com. Those with questions regarding these services should call (301) 951-3369. ■

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2004 Legislative Preview: What's Coming Down the Pike

BY EUGENE CASSEL, J.D.

Election Day is the lens through which all bills in Congress are seen. That's always the case, but in the second session of the 108th Congress, all the more so.

Clearly all eyes are on the presidential race.

One respected columnist recently wrote: "All sorts of current numbers suggest that President Bush should win this year's election in a landslide, but he and his re-election campaign are acting as though America is still a '50-50 nation.' "

In other words, President Bush is not taking a second term for granted. Meanwhile, Democrats are in a spirited debate over who will lead their challenge in November.

Just as important as the presidential race to APA is the makeup of the next Congress: a third of U.S. Senate seats are up, as are all 435 House seats—though fewer than 40 of those seats are in play.

Commentators predict that Republicans will increase their hold on the Senate, which is losing five Democratic senators—from Georgia, Florida, Louisiana, North Carolina, and South Carolina—to retirement. The retirements, it is believed, will force the party into an uphill and expensive struggle to hold on to its southern seats.

In the midst of all of this, APA continues to advocate for psychiatry and the care of our patients before Congress and the administration. Here's a 2004 legislative preview:

• The hot topic last year was passage of a sweeping bill to authorize a prescription drug benefit under Medicare and to otherwise "reform" the program. Now Sen. Edward Kennedy (D-Mass.) and Senate Minority Leader Tom Daschle (D-S.D.) are seeking to amend the new law, but Republicans say they see "no need for even technical corrections." Undoubtedly the Medicare prescription drug law will be a campaign issue.

• An insurance nondiscrimination (or mental health parity) bill will be a top item for the Senate, where its passage is likely. House prospects, despite 243 cosponsors, are less certain. House leaders have not made moving the bill to the floor a priority, but APA is working aggressively to change that.

• APA continues to advocate for an end to Medicare's discriminatory 50 percent coinsurance for outpatient psychiatric services. The Snowe-Kerry and Strickland-Murphy bills reflect a new approach: phasing down the coinsurance to 20 percent over six years. While we prefer immediate equalization, we support this method, which helps keep budget costs under control, even as it comes with a 10-year price tag of nearly $6 billion.

• SAMHSA reauthorization presents an opportunity to build on the work of the President's New Freedom Commission on Mental Health, which documented a crumbling public mental health system. The commission was not authorized to look at increased funding as a solution, but we believe such investments are necessary. We are part of a coalition working to secure additional funding for, and better organization of, our country's public mental health infrastructure.

• Independently and in coalitions, APA will continue vigorous support of NIMH, NIDA, and NIAAA research funding. Timely passage of Fiscal 2004 appropriations has been a problem, but it is likely that modest increases will go to NIH (3 percent). For Fiscal 2005, we anticipate that the president will recommend a 2 percent increase for NIH.

• APA is pushing hard for bipartisan action on the Keeping Families Together Act, which would halt the "forced custody relinquishment" of children by their parents to gain access to necessary mental health treatment through the Medicaid system. The bill has an excellent chance of passage in the 108th Congress.

There are many other bills—pertaining to privacy, genetic discrimination, patient safety, and more—that affect psychiatry and patients. I encourage your involvement. Start by exploring APA's online advocacy center at <www.psych.org> and joining our political action committee, APA*PAC*.

With general elections less than nine months away, your APA Division of Government Relations and APA*PAC* stand ready to work in a bipartisan fashion to advance our agenda—that which is good for patients, for science, and for your profession.

Stay tuned! ■

Eugene Cassel is acting director of APA's Division of Government Relations.

DB Leaders Take Part In State Legislative Summit

Liability reform, drug reimportation, and managed care were among the state legislative issues addressed at an AMA meeting. But for psychiatry, scope-of-practice challenges at the state level were central.

BY MARK MORAN

APA district branch representatives met with state medical societies, other specialty organizations, and leaders of the American Medical Association (AMA) during the AMA's 2004 State Legislative Strategy Conference last month in Scottsdale, Ariz.

Jeremy Lazarus, M.D., vice speaker of the AMA House of Delegates and chair of APA's Council on Advocacy and Public Policy, said the meeting marks the second year that APA has been invited to bring its district branch representatives to the AMA's state legislative conference.

Liability reform, drug reimportation, and managed care were among the legislative issues addressed at the meeting. But for psychiatry—as for many of the specialty organizations represented at the meeting—scope-of-practice challenges at the state level were central.

"The purpose was to make sure that district branches and their representatives are working with their state medical societies on legislative issues in general, and on psychologist prescribing in particular," Lazarus said.

At the meeting, Lazarus proposed, and AMA leaders endorsed, the idea of a national summit on scope-of-practice issues to be convened by the AMA.

After the conference in Scottsdale, APA representatives held their own strategy meeting to address continuing challenges posed by psychologist prescribing.

"It was an opportunity for all of us to exchange information about the issues that individual district branches have been facing around psychologist prescribing," said Alexander de Nesnera, M.D., treasurer and immediate past president of the New Hampshire Psychiatric Society. "We also learned what strategies have been useful in addressing that issue, what works and what doesn't work."

De Nesnera added that attendance at the AMA conference afforded an opportunity to hear about the scope-of-practice challenges confronting a number of other specialties.

He told *Psychiatric News* that psychologist-prescribing legislation was defeated last year in New Hampshire, with the help of APA's Division of Government Relations. But the issue has emerged again this year as a "study bill," requesting the legislature to study the appropriateness of psychologist prescribing.

In Maine, psychiatrists have faced challenges from psychologists because of the underserved rural areas in the state, said Edward Pontius, M.D., chair of the Maine Psychiatric Association's Committee on Legislative and Government Affairs, who also attended the AMA conference.

Pontius told *Psychiatric News* that the district branch in Maine is partnering with the Maine Academy of Family Physicians to provide psychiatrists who will be available on a volunteer basis for consultation with family doctors. Telepsychiatry—the use of technology to expand psychiatric practice across distances—is also a promising answer to access problems in the state, he said.

"Psychiatry is part of the house of medicine," Pontius said. "The scope-of-practice issues facing colleagues in other specialties are our issues as well. All of us realize that our collaboration with state medical associations is crucial. We need them to be there for us, and we need to be there for them." ■

APA's Political Action Committee Gives Contribution to Jeffords

David Fassler, M.D. (left), presents **Sen. James Jeffords** (I-Vt.) with a contribution from APA's political action committee, APA*PAC*. The presentation was made in Vermont.

Fassler is treasurer of the Vermont Psychiatric Association, a member of the APA*PAC* Board of Directors, and an APA trustee-at-large. Jeffords is a member of the Senate Health, Education, Labor, and Pensions Committee and the Finance Committee's health care subcommittee. Jeffords has cosponsored both the 2003 parity legislation and legislation to end Medicare's discrimination against mental illnesses. APA strongly supports both bills.

The visit is part of an ongoing program through APA*PAC* in which APA members educate federal and state legislators and policymakers about mental health issues.

Minority Psychiatry Fellows Discuss Clinical, Cultural Concerns

As it approaches the 30-year benchmark, SAMHSA's Minority Fellowship Program brings together top federal officials for mental health with current and past minority fellows in a conference about cultural competence and reducing health disparities.

BY KATE MULLIGAN

Speakers at the First National SAMHSA Minority Fellowship Program (MFP) Conference last December were united in their praise of Jeanne Spurlock, M.D.

Spurlock was APA's deputy medical director when the National Institute of Mental Health (NIMH) established the fellowship program in 1975 and oversaw the program until her retirement in 1991.

Former fellow Patricia Ordorica, M.D., associate chief of staff for mental health and behavioral sciences at the Tampa VA Medical Center, told the luncheon audience, "Jeanne was known as the conscience of APA. It was a blessing to be involved in the program."

Ordorica was the 2003 winner of the 2003 Jeanne Spurlock Minority Fellowship Achievement Award.

James Jones, Ph.D., director of the MFP for the American Psychological Association, added, "Jeanne was also the conscience of NIMH and the Congress."

Ordorica also praised Marilyn King, APA's senior program manager for the MFP, as "the rock of the program and [the person] responsible for its current success."

MFP's impact was demonstrated in tangible and intangible ways during the two-day conference.

The directors of the three centers that comprise the Substance Abuse and Mental Health Services Administration (SAMHSA) delivered keynote addresses, as did King Davis, Ph.D., executive director of the Hogg Foundation for Mental Health and chair of the Committee on Health Disparities of the New Freedom Commission on Mental Health.

Other sessions focused on the areas that SAMHSA identified as being of "most interest" to fellows: community-based treatment and prevention, children and families, co-occurring disorders, substance abuse treatment and prevention, HIV/AIDS, trauma and violence, and cultural competence and reducing health disparities.

Attendance considerably exceeded the planners' expectations because of the unexpectedly large number of former fellows who came. Twenty former and six current APA fellows attended.

The program, which provides fellowships in psychiatry, psychology, nursing, and social work for graduate work to members of minority groups, has been enhanced and modified during its 29-year history.

With the support of AstraZeneca Pharmaceuticals in 1997, for example, APA was able to add 20 fellows each year to those supported with federal funds.

The total number of fellows varies from year to year, depending on the level of federal support. More than 300 fellows have received support during the past 29 years.

King said, "Many of the most active members of APA governance are past and present MFP fellows. The program is not only enormously valuable to the trainees as individuals, but also to psychiatry as a profession and to our patients." ■

Current and past fellows in APA's minority fellowship programs join APA staff at the First National SAMHSA Minority Fellowship Program Conference.

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FDA Gains Long-Sought Power To Order Pediatric Drug Testing

After years of frustration, the FDA finally has the authority to require the study of drugs' safety and efficacy in children.

BY JIM ROSACK

With the signature of President Bush on December 3, 2003, the Food and Drug Administration (FDA) ended nearly 10 years of frustration, gaining the authority to force drug makers to prove that their medications are safe and effective in children and adolescents.

The enactment of the Pediatric Research Equity Act of 2003 allows the FDA to achieve a long-sought goal. Since 1997, when Congress first required the agency to "promote research into pediatric use of adult medications," the FDA has struggled to gather data on the safety and efficacy of medications prescribed every day for children, without the evidence base to support this use.

The agency first developed the concept of "pediatric exclusivity"—voluntary submission by drug manufacturers of minimal data on safety of their medications in children in exchange for extended patent protection. When the exclusivity program proved not to be very productive, the agency formulated the "pediatric rule," requiring submission of the data included with any new drug application. In October 2000, however, the pediatric rule was struck down in federal court, when justices agreed with industry claims that the FDA lacked the statutory authority to require the research (*Psychiatric News*, September 19, 2003).

"When it goes into effect today," said FDA Commissioner Mark McLellan, M.D., on December 3, 2003, "the Pediatric Research Equity Act of 2003 will allow the FDA to close the knowledge gap when it comes to treating children. The FDA will now have clear authority to require pediatric studies of drugs, when other approaches are not sufficient to ensure that drugs are safe and effective for children."

The law grants the FDA the authority to require the submission of data on safety and effectiveness, as well as on dosing and administration, as part of any submission of an application for approval of a new active ingredient, new indication, new dosage forms, new dosing regiment, or new route of administration.

If the course of a disease and the effects of the drug treating it are "sufficiently similar in adults and pediatric patients," the FDA may waive the requirement if it can be concluded that "pediatric effectiveness can be extrapolated from adequate and well-controlled studies in adults."

Also, if adult studies are completed significantly in advance of pediatric studies, a drug may be approved for adult use, with a date set for subsequent submission of pediatric data.

The new law should significantly boost the study of psychotropic safety and efficacy in children and adolescent populations. To date, only two such medications have indications for pediatric use: fluoxetine (Prozac), for major depressive disorder in patients aged 7 and older and obsessive-compulsive disorder in patients aged 8 and older; and atomoxetine (Strattera), for treatment of ADHD in patients aged 6 and older. Fluvoxamine (Luvox) has pediatric safety and dosing information for patients with obsessive-compulsive disorder aged 8 and older, included in its approved labeling, but does not carry a pediatric indication.

In December 2000 APA partnered with the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics to call on the AMA to lobby for passage of legislation equivalent to the Pediatric Research Equity Act (*Psychiatric News*, January 19, 2001).

The Pediatric Research Equity Act can be accessed online at <http://thomas.loc.gov> by searching on the bill number, S 650. ■

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Public Education Key Part Of Foundation's Mission

The American Psychiatric Foundation is APA's unsung hero as it labors quietly in the background.

BY MEGHAN SAYER

The American Psychiatric Foundation is working behind the scenes to help community groups educate the public on mental health issues and the importance of seeking help.

Two groups that recently got financial assistance from the foundation are the Bucks County (Pa.) Crisis Response Team (BCCRT) and the New River Valley Community Disaster Response Coalition in southwest Virginia.

BCCRT sought to increase awareness in schools, churches, police departments, and businesses about the crisis-intervention services it provides.

BCCRT had great success in increasing awareness and delivered a variety of interventions to the community. Such interventions included debriefing bank employees involved in a robbery and employees coping with a shooting incident at their work site. The organization also provided assistance to members of a local chapter of Mothers Against Drunk Driving by debriefing schools during and after special driving-while-intoxicated re-enactments.

The foundation also provided funding to the New River Valley Community Disaster Response Coalition (CDRC). The coalition was formed by Dorinda Miller, Ph.D., of the Academy of Healing Arts Inc. and Amy Forsyth-Stevens of the Mental Health Association of the New River Valley, Va. CDRC consists of several mental health organizations and private practitioners who work together to educate community members about the mental health and emotional consequences of terrorism and disaster.

The CDRC's efforts have had tangible results. More than 960 people in southwest Virginia benefited from 28 community educational presentations by learning about the impact of terrorism and war, the importance of seeking help, and where to seek help. The CDRC worked to inform students, teachers, school officials, the Retired Seniors Volunteer Program, local congregations, the U.S. Postal Service, and other individuals about mental illness and how to seek care.

Community agencies were enthusiastic about being involved in the CDRC project and building relationships to support the community in the event of a terrorist attack or natural disaster. And, as they had hoped, there is now a growing interest is developing a similar community disaster-response coalition in more remote areas of southwest Virginia.

These grants are just a few examples of how the American Psychiatric Foundation is working to educate the public about mental health issues and the importance of seeking care. More information on the foundation, including how to make a tax-deductible contribution, is posted online at <www.PsychFoundation.org>. ■

Meghan Sayer is a development officer at the American Psychiatric Foundation.

Foundation Sets $1 Million Annual Fund Goal for 2004

The American Psychiatric Foundation has announced the establishment of a $1 million fundraising goal for its Annual Fund in 2004. If reached, it will mark the first time that the foundation's Annual Fund has met or exceeded the $1 million level.

"We believe that with the support of the APA membership, we can reach this fundraising goal," said Foundation President Altha J. Stewart, M.D. "The Annual Fund provides the critically needed resources to fund many important programs such as the National Partnership for Workplace Mental Health and for grants that are provided to small local organizations that are carrying out innovative programs in their communities that educate people that mental illness is real and treatable."

The foundation is a charitable and educational subsidiary of APA. Contributions to the foundation's Annual Fund will be used to support educational programming and grants that raise awareness of mental illness and the importance of early intervention, as well as increase access to quality mental health services. The foundation is also a supporter of the American Psychiatric Institute for Research and Education.

More information about the foundation, including how to make a tax-deductible contribution, is posted online at <www.PsychFoundation.org>. ■

Volunteers Needed

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

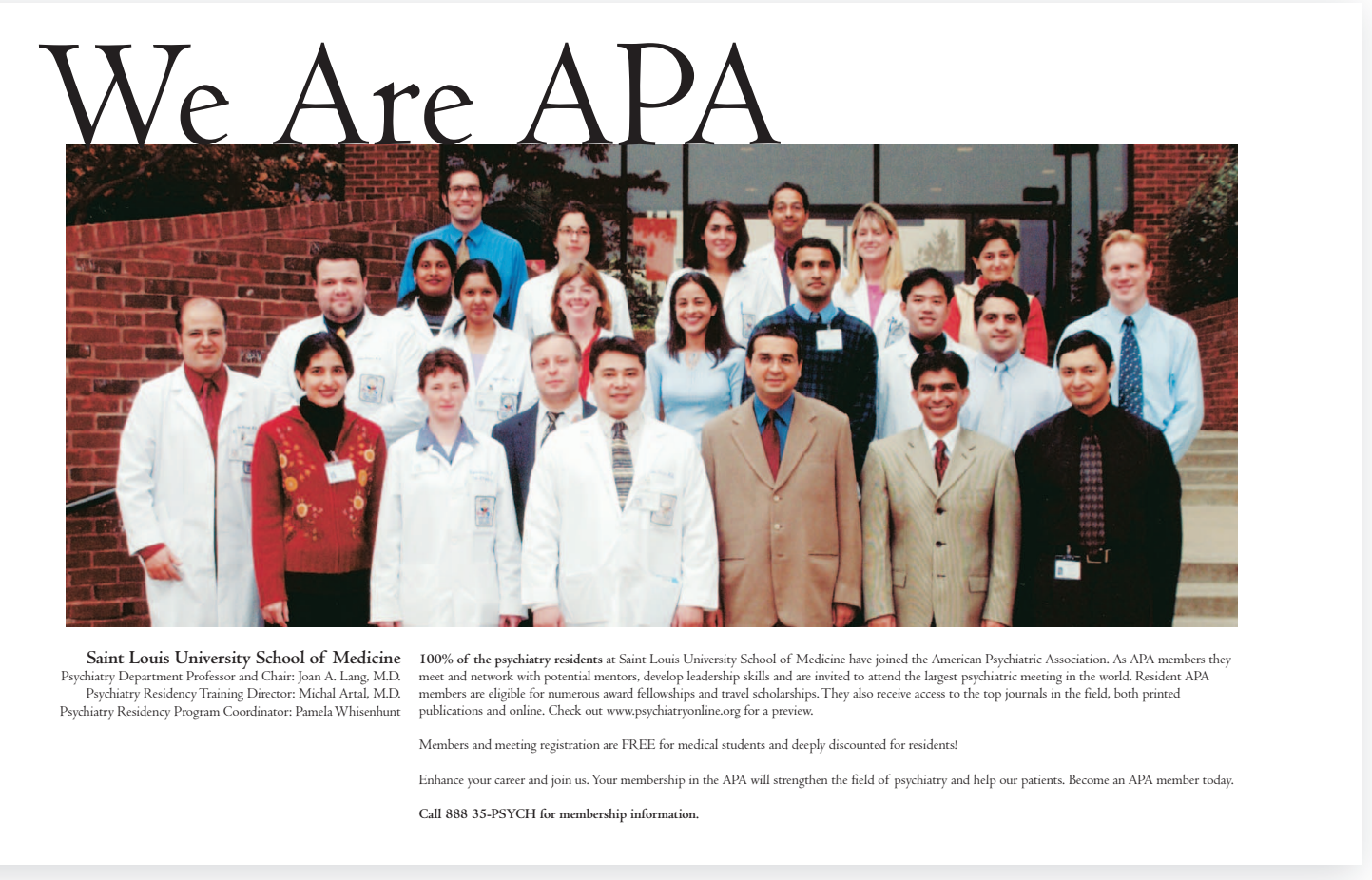
Another Residency Program Joins APA's 100% Club

St. Louis University School of Medicine's department of psychiatry is the eighth institution to have all of its psychiatry residents become members of APA.

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

The first 10 training programs whose residents all become APA members can submit a photo of their program members—residents, training directors, and department chair—and the photo will be turned into a poster and mailed to every medical school in the United States and Canada to encourage medical students to join APA (see photo). These residents will also be given a 25 percent discount on national membership dues after their first year of membership.

(The first year of membership at the national level of APA is free for residents and $80 thereafter for U.S. residents and $50 for Canadian residents. Membership for medical students is free.)



Front row, from left: Nader Wassef, M.D., Roomana Arain, M.D., Heather Brice, M.D., Arturo Taca, M.D., Sanjeev Kamat, M.D., Muhammad Naeem, M.D., Arshad Bhatt, M.D. Middle row, from left: Vadim Baram, M.D., Joao Ramos, M.D., Shajitha Nawaz, M.D., Jennifer Shashek, M.D., Sherifa Iqbal, M.D., Sanjeev Kamat, M.D., Marlon Mangahas, M.D., Mohammad Arain, M.D., Joseph Behrmann, M.D. Top row, from left: Ratnasri Mogallapu, M.D., James Conour, M.D., Veneta Stoyanova, M.D., Layla Ziaee, M.D., Farzana Amin, M.D., and Shannon Jenings, M.D.

More information is available from Nancy Delanoche of APA's Division of Education, Minority, and National Programs at (703) 907-8635. Programs that are interested in signing up all their residents should also contact Delanoche. ■

Safety-Net Providers Learn Value of Strong Bottom Line

"No margin, no mission," says a new breed of leaders of safety-net institutions who are developing entrepreneurial skills to deal with declining fiscal resources.

BY KATE MULLIGAN

What enables the nation's health care safety net to survive? Fortunately, it isn't only money, according to a recent analysis by the Center for Health System Change (HSC).

Every two years HSC researchers interview individuals involved directly and indirectly in providing safety-net services to low-income people in 12 nationally representative communities.

According to HSC's issue brief, "The Health Care Safety Net: Money Matters but Savvy Leadership Counts," the backbone of the safety network is "providers, such as community health centers and public hospitals, whose main mission is to provide care to low-income people, including the uninsured."

During the last two years, the safety net has faced increasing economic pressure because of its dependence on state and local tax revenues. Demands for its services are increasing because of the growing number of uninsured Americans.

HSC, which has been tracking the safety net's fate since 1996, found that "most safety net providers in the 12 communities have become stronger and improved their business practices. They have increased capacity by enhancing and expanding facilities and services and strengthened their finances to protect future viability. Generally, these changes have increased primary care and hospital services available to low-income people, although the safety net remains much more limited in providing specialty, mental health, and dental services."

Business acumen is one of the key attributes that promote viability. Leaders of safety-net organizations have developed into or been replaced by entrepreneurial business managers who are more effective at day-to-day operations and fiscal strategizing. Among the strategies identified by these leaders are to streamline operations and improve productivity, improve payment collection, leverage economies of scale and share technical expertise, attract more privately and publicly insured patients to improve payer mix, and raise funds and apply for grants.

Managers of a public hospital in New Jersey, for example, improved the hospital's accounting system so that they were better able to demonstrate the need for additional state charity-care funds. A community health center in Syracuse, N.Y., created a foundation to raise money for equipment and capital projects and formed partnerships with other groups or institutions.

"No margin, no mission" has become a mantra conveying the idea that without financial viability, institutions will be unable to fulfill their mission.

Development of community support and exercise of political leadership also help strengthen the safety net. Ballot initiatives have become a means of demonstrating that support. In Phoenix, a seriously underfunded public hospital was caring for the city's uninsured and a growing immigrant population. Advocates mobilized the support of the community and other hospitals to obtain the state legislature's approval for a ballot initiative that would establish a tax district to generate revenues for the hospital.

In Greenville, S.C., an alliance of health and business organizations and private foundations served as a catalyst to coordinate new clinic-based and private-physician services for low-income people.

Governors have promoted and protected public-insurance expansions. Arkansas Gov. Mike Huckabee (R), for example, fought successfully for new taxes to avoid cuts in Medicaid coverage for children.

HSC researchers also acknowledged challenges for the safety net in the coming years. Larger state and local budget deficits in Fiscal 2004 are often leading to deeper cuts in health care. Some state and local governments also are paring back the amount of direct safety-net funding they provide through uncompensated care pools and other mechanisms.

Demands for safety-net care will grow as people lose private insurance because of unemployment and rising health insurance premiums, and public insurance because of state budget cuts. HSC found that between 1997 and 2001 the proportion of physicians nationally providing any charity care declined from 76 percent to 72 percent, causing further pressure on the net.

The 12 communities that HSC studies are Syracuse, N.Y.; Greenville, S.C.; Boston; Cleveland; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; and Seattle.

"The Health Care Safety Net: Money Matters but Savvy Leadership Counts" is posted online at <www.hschange.org/CONTENT/591/>. ■

Erratum

The conversion factor for the 2004 Medicare Physician Fee Schedule was listed incorrectly in the January 2 issue as 37.334835. The correct conversion factor for 2004 is 37.3374. This information, as well as the corrected fees for psychiatric services, is posted online on APA's Web site at <www.psych.org/members/newsletters/ppmc/medicarefeesched11604.pdf>. ■

Medicare Has Several Options For Controlling Costs

As a strategic purchaser, Medicare could identify beneficiaries who might gain from disease management, recalibrate hospital payments to avoid distortions that increase costs, and offer bonuses to hospitals that achieve quality goals.

BY MARK MORAN

The government needs to be a smarter consumer if it wants to rein in Medicare spending, according to two recent studies.

Both studies appeared in the December 4, 2003, *Health Affairs.*

In one study, Steve Lieberman, Ph.D., assistant director of the Health and Human Resources Division at the Congressional Budget Office, and colleagues suggested that the Medicare program should focus strategies for improving cost efficiency on those beneficiaries who consume the largest amount of health care resources.

They compared two alternative approaches for lowering the growth of Medicare spending.

The first approach is to focus on high-cost individuals to make health care for the sickest beneficiaries more efficient, possibly through techniques like disease management. A second approach, advocated by some health policy experts, is to focus on high-spending regions to change practice patterns, reducing ineffective and "supply-sensitive" health care treatment—that is, those procedures that vary in frequency based on the number of providers in an area.

Based on an analysis of spending data, Lieberman and colleagues found that focusing on high-cost beneficiaries who typically have multiple chronic conditions has more potential to control health care cost growth.

"Medicare spending is extremely concentrated among a very small group of people," Lieberman said in a Webcast interview about the study. "Five percent of the beneficiaries, who are the most expensive 5 percent, cost as much as the remaining 95 percent of the beneficiaries."

Conversely, he said, the 40 percent of the Medicare population that is the least costly to care for account for only about 1 percent of Medicare spending—an average of less than $200 per person per year.

"So they are essentially not quite free, but pretty close to it, and there isn't much savings that would appear to be picked up by focusing on these people," Lieberman said.

Lieberman and colleagues found that if Medicare focuses on reducing spending for the costliest 1 percent of beneficiaries, it would be getting at about 17 percent of total spending. Conversely, if Medicare focuses on the costliest Hospital Referral Regions, in which 1 percent of beneficiaries live, those beneficiaries represent only 1.2 percent of total Medicare spending.

"From a budgetary perspective, a strategy centered on high-cost individuals could hold the promise of greater 'bang for the buck,' " Lieberman and his colleagues said. "Simply, there's more money concentrated in fewer individuals."

In an accompanying article, Robert Berenson, Ph.D., a senior fellow at the Urban Institute, proposed transforming Medicare from a payer of claims to a "strategic purchaser"—basically, a smart consumer—that seeks out high quality and acceptable cost.

As a strategic purchaser, Medicare would identify beneficiaries who could benefit from disease management, recalibrate hospital payments more frequently to avoid market distortions that increase Medicare costs, and offer bonuses to hospitals that achieve quality goals.

During the Webcast interview, Berenson

please see ***Medicare*** *on page 37*

Health Care Spending Trends Down Slightly

BY KATE MULLIGAN

Health care spending growth for privately insured Americans slowed in the first half of 2003, according to a study released last December by the Center for Studying Health System Change (HSC).

The growth was 8.5 percent as contrasted to growth of 10 percent in the second half of 2002. The 1.5 percent decline was the largest six-month drop since the early 1990s. Prescription drug spending slowed the most, rising only 8.5 percent in the first half of 2003, nearly 5 percentage points less than the 13.4 percent increase in the second half of 2002.

Despite the decline in the rate of growth, health care spending in the first six months of 2003 grew nearly three times faster than growth in the overall economy.

"Increased patient cost sharing is probably an important factor in the slowing of cost trends, but few experts expect this tool to substantially lower cost trends over the long term," said Paul B. Ginsburg, Ph.D., co-author of the study and president of HSC.

He and co-author Bradley Strunk concluded, "The slowing of underlying cost trends is likely to bring an end, perhaps in 2004, to the long period of accelerating employer-sponsored health insurance premium trends, which reached a peak in 2003 at 13.9 percent. . . . However, cost and premium trends are still likely to remain well in excess of trends in gross domestic product for the foreseeable future."

"Tracking Health Care Costs: Trends Slow in First Half of 2003" is posted online at <www.hschange.org/CONTENT/633/>. ■

AMA's Resident and Fellow Section Moves in Right Direction

BY MANISHA PUNWANI, M.D.

When I joined my residency program, I had no idea how much strength there can be in the collective force that residents represent. We residents work long hours and spend the remainder of our time surviving the challenges of daily living. While it is hard to devote already scarce time to the medical organizations that represent and advocate for us, doing so is vitally important—there is absolutely nothing to lose and so much to gain and learn.

Manisha Punwani, M.D., is a psychiatry fellow at the University of Massachusetts Medical School, the MIT deputy representative from Area 2 to the APA Assembly, and a resident member of the AMA's Reference Committee on Constitution & Bylaws.

APA not only provides academic resources for psychiatry residents but also gives them opportunities to participate in organized psychiatry. Such participation is intended not only for residents interested in becoming leaders in the field but also for residents who want an opportunity to work with prominent psychiatrists, understand how psychiatry is marching forward on all levels, and contribute to its future.

Probably the most visible members-in-training (MIT) in the APA leadership are the MIT trustee and MIT trustee-elect. Currently they are Angela Harper, M.D., and Susan Rich, M.D., respectively. Every year in APA's election, MITs select an MIT trustee-elect, who serves for a year in that position and then becomes the MIT trustee for a year.

Fourteen members-in-training serve on the APA Assembly's Committee of Area Member-in-Training Representatives, with each APA Area having one representative and one deputy representative. Every year the Areas elect a deputy representative, who assumes the representative position a year later. To find out the names and contact information of your Area representatives, call your district branch office; district branch information is also posted on APA's Web site at <www.psych.org/dbs_state_soc/db_list/db_info_dyn.cfm>.

APA also has many other leadership opportunities available to members-in-training. More information on them is posted on APA's Web site at <www.psych.org/edu/res_fellows/index.cfm>.

My election into the AMA Resident and Fellow Section (AMA-RFS) as the APA delegate in May 2003 has enlightened me about how much the AMA-RFS does for residents. It surprised me to learn that many psychiatry residents are not even aware of the existence of the AMA-RFS. After participating in the AMA's interim meeting in Honolulu last December (*Psychiatric News*, January 2) and attending the forum for residents and fellows, I thought it might be worthwhile to share my experience with other resident and fellow colleagues.

The AMA-RFS is the largest organization of residents in the United States. It was created in 1974 to represent and advocate for residents, train young physician leaders, and educate residents about issues con-

please see ***Residents' Forum*** *on page 37*

Five Residents Selected for Child Fellowships

APA received a second unrestricted educational grant from Shire Pharmaceuticals for another group of residents to encourage them to work in child and adolescent psychiatry. The grant will underwrite the travel, meeting registration, and limited expenses of five residents to APA's annual meetings in 2004 and 2005 in New York City and Atlanta, respectively.

The residents selected for these fellowships are Jennifer Cheng, M.D., of the University of Washington in Seattle; Patricia A. Daly, M.D., of the Dartmouth-Hitchcock Medical Center in Lebanon, N.H.; Kareem Ghalib, M.D., of the New York Presbyterian Hospital Program at Columbia University in New York City; Giuseppe Raviola, M.D., of the MGH/McLean Adult Psychiatry Residency Training Program in Boston; and Lawrence Tucker, M.D., of the UCLA Neuropsychiatric Institute in Los Angeles.

The APA/Shire Child and Adolescent Psychiatry Fellowship program is designed to develop interest among general psychiatry residents in pursuing careers in child and adolescent psychiatry by providing educational opportunities that would not otherwise be available to them. Showing residents the most exciting new clinical research and the most successful public programs for the treatment of seriously mentally ill children and adolescents are two important issues in this recruitment.

The fellows also will have unparalleled opportunities to meet and network with leaders in child and adolescent psychiatry. They will be matched with mentors who will consult with them about sessions on the program of special interest. In addition, they will meet as a group to talk about the annual meeting presentations.

This fellowship program is overseen by the APA Council on Children, Adolescents, and Their Families and is administered by the project manager of the APA Office of Children's Affairs. ■

Troubling Gene Variant Shows Up Side in Depression

The E4 variant of the APOE gene is well known to increase the risk of Alzheimer's disease. However, the variant may also do something positive: enhance response to certain antidepressants.

BY JOAN AREHART-TREICHEL

A particular variant of the gene that makes the fat-metabolizing enzyme apolipoprotein E (APOE) has acquired considerable notoriety. It is, of course, the E4 variant. Having the E4 variant of the APOE gene increases the risk of developing late-onset Alzheimer's disease, numerous studies have shown. Having the variant also seems to make people more vulnerable to brain damage following a head injury or to cognitive decline after heart surgery.

Possessing the E4 gene form may not be a total curse, however. It may also speed up response to certain antidepressants, suggests a study conducted by Alan Schatzberg, M.D., chair of psychiatry at Stanford University, and colleagues and in press with *Biological Psychiatry*.

The study included 246 cognitively intact subjects aged 65 years or older with major depression. The subjects were randomly chosen to receive either 20-40 mg daily of the antidepressant paroxetine or 15-45 mg daily of the antidepressant mirtazapine over an eight-week period. All subjects were assessed to see whether they carried either one or two copies of the E4 variant of the APOE gene.

Results revealed that 92 subjects who were given paroxetine did not have an E4 variant, whereas 30 did, and 93 who were given mirtazapine did not have an E4 variant, whereas 31 did; thus, 25 percent of subjects taking paroxetine and 25 percent of subjects taking mirtazapine had one or more copies of the variant. Finally, the researchers assessed the clinical outcomes for all four groups of subjects and compared them.

Subjects receiving paroxetine and possessing an E4 gene form, the scientists found, had responded slower to paroxetine than had subjects getting paroxetine but not possessing the E4 gene variant. This finding suggested that having the maverick E4 form impaired antidepressant response—exactly what the researchers had anticipated. However, mirtazapine subjects with the E4 variant had responded faster to mirtazapine than the mirtazapine subjects without the E4 form. This finding suggested that having the E4 variant enhanced the antidepressant response—something that the investigators had not expected.

What's more, these differences in response could not be explained by antidepressant dosage, antidepressant compliance, gender, ethnicity, baseline depression, or other factors.

Thus, "the APOE E4 allele may affect antidepressant treatment outcome," Schatzberg and his team concluded in their study report, "but the effect depends on the medication."

If this is so, then why might having a copy of the E4 gene form speed the impact of mirtazapine, but not that of paroxetine? "The neurobiological basis for the differential effect. . . cannot be determined from [our study's] results," the researchers stated in their report. Nonetheless, they proposed this possible explanation: "[W]hereas paroxetine has a primarily serotonergic mode of action, mirtazapine has both serotonergic and noradrenergic actions. [Thus] it is conceivable that in elderly depressed patients, the E4 [gene variant] affects brainstem noradrenergic and serotonergic neurons so that the dual-action-agent mirtazapine results in a rapid response, but the single-action-agent paroxetine has a slower response."

An abstract of the study, "The Apolipoprotein E E4 Allele and Antidepressant Efficacy in Cognitively Intact Elderly Depressed Patients," is posted online at <www-east.elsevier.com/bps/abstracts/27213abs.htm>. ■

Social Anxiety Can Linger After Recovery

BY JOAN AREHART-TREICHEL

Even if individuals with schizophrenia manage to throw off the yoke of positive and negative symptoms, they may still fear fitting into society.

In a study of some 80 outpatients with schizophrenia who had recovered partially or totally from their illness, 36 percent were found to suffer from social anxiety disorder, Stefano Pallanti, M.D., of the Institute of Neurosciences in Florence, Italy, and colleagues found. Further, no differences in negative and positive symptoms were discovered between those subjects who experienced social anxiety and those who did not.

Thus, "social anxiety is a highly prevalent, disabling condition in outpatients with schizophrenia that is unrelated to clinical psychotic symptoms," Pallanti and his coworkers concluded in the January *American Journal of Psychiatry*.

The subjects who were socially anxious had symptoms of that condition that were as severe as those in 27 individuals who had social anxiety disorder as a primary diagnosis, the researchers learned. Finally, subjects who had both schizophrenia and a phobia about interacting with other people had a lower quality of life and a higher rate of suicide attempts than did those subjects who had schizophrenia without social anxiety.

"If these observations are confirmed by further studies in larger samples," the researchers wrote in their study report, "adequate. . . treatments will need to be sought. Currently there are no operational guidelines for the treatment of comorbid social anxiety disorder in schizophrenia."

The study, "Social Anxiety in Outpatients With Schizophrenia: A Relevant Cause of Disability," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/1/53?>. ■

Compound May Be Effective In Reducing Alzheimer's Plaques

Ten patients have been receiving clioquinol at a dosage of 500 mg/d to 750 mg/d for more than 18 months in an open-label extension study. No adverse events attributable to clioquinol have been detected.

BY MARK MORAN

Clioquinol appeared to decrease levels of plasma beta amyloid, the protein whose toxic accumulation in the brain is believed to be centrally linked to Alzheimer's disease, and led to improvement on the Alzheimer's Disease Assessment Scale (ADAS) score in those with the most severe disease.

The compound, which had been withdrawn for oral use in 1970 because of its association with subacute myelo-optic neuropathy, was well tolerated. Authors of the small study, appearing in the December 2003 *Archives of Neurology*, said that the results argue for reconsideration of the drug's use and for larger clinical trials.

Clioquinol is a compound that inhibits zinc and copper ions from binding to beta amyloid, thereby promoting the dissolution of that protein and diminishing its toxic properties.

In the study, 36 patients were randomized to receive treatment with clioquinol or placebo. The oral dosage of clioquinol was 125 mg twice daily from weeks 0 to 12, 250 mg twice daily from weeks 13 to 24, and 375 mg twice daily from weeks 25 to 36.

Patients who had a baseline ADAS score of 25 or more and were in the treatment arm showed a trend toward significant improvement on the score at weeks 4 and 24, compared with patients who were in the placebo arm and also had baseline scores of 25 or more. Plasma beta-amyloid levels declined in the clioquinol group and increased in the placebo group.

"The findings support a proof of concept in humans that a drug targeting metal beta-amyloid interactions can have a significant effect on beta-amyloid metabolism and, through this, a beneficial modification on the progression of Alzheimer's," wrote Craig B. Ritchie, M.B.Ch.B., and colleagues at the Mental Health Research Institute of Victoria at the University of Melbourne, Australia.

"The significant benefit seen in the more severely affected treatment group at four weeks [on the ADAS scores]. . .may represent the short-term effect of clioquinol neutralizing the neurotoxicity of the soluble pool of beta amyloid."

The authors acknowledged that safety is of concern in a study involving the chronic administration of a drug with a history of adverse events. Clioquinol-associated optic neuropathy was suspected in one patient with a history of eye disease. But they said a direct causal link to clioquinol remains uncertain, given that "disturbances of color vision and other ophthalmologic changes occur during the natural history of Alzheimer's disease."

They added that 27 patients have agreed to participate in an open-label extension study of clioquinol, and that 10 of those have been receiving the drug at a dosage of 500 mg/d to 750 mg/d for more than 18 months. No clioquinol-attributable adverse events have developed in any of these patients, they reported.

In an accompanying editorial, Roger N. Rosenberg, M.D., editor of the *Archives of Neurology*, said zinc-copper chelation offers promise as a new therapeutic strategy. "Clearly, it is an innovative therapeutic approach to Alzheimer's disease and merits a closer and more comprehensive assessment in larger clinical trials."

An abstract of the study, "Metal-Protein Attenuation With Iodochlorhydroxyquin (Clioquinol) Targeting A Amyloid Deposition and Toxicity in Alzheimer Disease: A Pilot Phase 2 Clinical Trial," is posted online at <http://archneur.ama-assn.org/cgi/content/abstract/60/12/1685>. ■

Association News

Suicide Guideline Available on APA Web Site

APA issued its first guideline on the assessment and treatment of patients with suicidal behaviors last November, and the guideline is now posted on APA's Web site at <www.psych.org/psych_pract/treatg/pg/prac_guide.cfm>.

The guideline, titled "Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors," was first published as a supplement to the November 2003 issue of the *American Journal of Psychiatry*. Its aim is to help psychiatrists better understand the prevalence rates, risk factors, and protective factors for patients who are at risk for suicide (*Psychiatric News*, July 18, 2003).

Also included are recommendations for psychotherapeutic and pharmacologic treatments for at-risk patients.

Douglas Jacobs, M.D., who is executive director of Screening for Mental Health and an associate clinical professor of psychiatry at Harvard Medical School, chaired the work group that developed the guideline.

The practice guideline will also be available for purchase through American Psychiatric Publishing Inc. in its next compendium of practice guidelines, titled *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2004*. The compendium is scheduled for a May release.

The practice guideline book can be purchased from American Psychiatric Publishing Inc. by phone at (800) 368-5777 or online at <www.appi.org>. ■

Did Delay of Ephedra Ban Cause Unnecessary Deaths?

Sidney Wolfe, M.D., of Public Citizen's Health Research Group, charges that there have been more than 155 deaths of ephedra users and that the FDA action comes too late. Ephedra has been linked to a variety of adverse events, including some reported cases of psychosis.

BY MARK MORAN

The Food and Drug Administration (FDA) is banning sale of dietary supplements containing ephedrine alkaloids (ephedra). The agency is also urging consumers to stop using ephedra products immediately.

Health and Human Services Secretary Tommy Thompson issued a consumer alert on the safety of dietary supplements containing ephedra and has notified manufacturers of its intent to publish a final rule on dietary supplements containing ephedrine alkaloids. The rule will state that dietary supplements containing ephedrine alkaloids present an unreasonable risk of illness or injury.

The rule would have the effect of banning the sale of dietary supplements containing ephedrine alkaloids when it becomes effective, 60 days following publication. Sixty-two firms that market dietary supplements containing ephedra and ephedrine alkaloids received the letter from the FDA alerting them of the final rule.

> "All the scientific evidence and legal authority to ban ephedra was in place at the time of our petition, which we filed in September 2001."

Thompson said the final rule "will formalize its conclusions that dietary supplements containing ephedrine alkaloids present unreasonable risks to those who take them for any reason."

Ephedra, also called Ma huang, is a naturally occurring substance derived from botanicals. Its principal active ingredient is ephedrine, which when chemically synthesized is regulated as a drug. In recent years ephedra products have been extensively promoted for use to aid weight loss, enhance sports performance, and increase energy. The supplement has also been linked to a variety of adverse events, including psychiatric complications.

This year the RAND Corporation's Southern California Evidence-Based Practice Center issued the report "Ephedra and Ephedrine for Weight Loss and Athletic Performance Enhancement: Clinical Efficacy and Side Effects." The report provided evidence that ephedra is associated with major health risks—including psychiatric effects—and found only limited evidence of health benefits resulting from its use.

The RAND Corporation's review of some 16,000 adverse-event reports revealed two deaths, four heart attacks, nine strokes, one seizure, and five psychiatric cases involving ephedra in which the records appeared thorough and no other contributing factors were identified.

In addition, three cases of psychosis related to use of ephedra-containing herbal supplements were reported in the July 2003 *Southern Medical Journal*.

Study authors Ruth Walton, M.D., and Gail H. Manos, M.D., of the department of psychiatry at Portsmouth Naval Medical Center in Portsmouth, Va., observed, "Toxicity may occur at only two or three times the maximum therapeutic dose of 150 mg/d. Most reports have focused on medical complications such as stroke, seizure, hepatic toxicity, or even death" *(Psychiatric News*, November 21, 2003).

In 1997 the FDA first proposed a rule on dietary supplements containing ephedra including requiring a warning statement on these products. The agency modified this proposed rule in 2000, and a year ago the agency announced a series of comprehensive actions designed to protect Americans from the potentially serious risks of dietary supplements containing ephedra.

At least one critic charged the FDA's action comes too late.

Sidney Wolfe, M.D., director of Public Citizen's Health Research Group, claimed that the FDA knew of more than 155 deaths of ephedra users and said the agency had waited more than two years after Public Citizen first petitioned the agency to ban the supplement.

The delay "shows the dangerous cowardice of FDA Commissioner Mark McClellan and HHS Secretary Tommy Thompson," Wolfe said. "All the scientific evidence and legal authority to ban ephedra was in place at the time of our petition, which we filed in September 2001. One reason major manufacturers have stopped selling ephedra is that the companies have become uninsurable because of massive losses in product liability cases. When we filed our petition, there were reports of 81 ephedra-related deaths. Now, after that number has nearly doubled and very little ephedra is being manufactured, the FDA finally announces a ban.

"This is an inexcusable dereliction of responsibility by an agency that has acted more like an ephedra sales extension agency than the public health agency it is supposed to be," Wolfe said.

More information on the FDA's actions related to ephedra can be found online at <www.fda.gov/ola/2003/dietarysupplements1028.html>. ■

Researchers Try to Quantify Etiology of Schizophrenia

Schizophrenia appears to be predominantly a product of nature, with a little bit of nurture mixed in.

BY JIM ROSACK

In this era of the Human Genome Project, questions of "nature vs. nurture" are increasingly being met with definitive answers that insist the cliché be reworded to "nature *plus* nurture."

An intriguing recent study, little noted in the popular press, determined that schizophrenia was 81 percent genetic and 11 percent environmental—give or take a few percentage points, of course.

Quantifying the genetic and environmental contributions to major disorders is an increasingly popular task of genetic researchers; however, few (if any) reports have attempted to determine so precisely the components for serious and persistent mental illness. Previous reports of genetic-environmental interactions in mental illness have focused more on qualitative and descriptive terms. The report of more than an 80 percent genetic component to schizophrenia appears to change that status quo.

The new study, funded by the National Institute of Mental Health, was conducted by Patrick Sullivan, M.D., a professor of genetics and psychiatry at the University of North Carolina at Chapel Hill, and his colleagues at the Virginia Institute for Psychiatric and Behavioral Genetics. Their findings appeared in the December 2003 *Archives of General Psychiatry*.

Dozen Twin Studies Analyzed

Sullivan and his colleagues performed a quantitative meta-analysis of 12 published twin studies of schizophrenia and not surprisingly confirmed the studies' claims that schizophrenia is a complex, multigene trait that is highly heritable.

However, the Sullivan report appears to be the first to quantify the risk of developing schizophrenia as being 11 percent environmental. Along with the 81 percent genetic contribution, that leaves just 8 percent to the "we don't know" margin of error.

Sullivan's group searched the literature for studies of schizophrenia in twins. They found 14 reports, but discounted two of those in their analysis because they did not use systematic recruitment and were not blinded as to whether the twins were monozygotic or dizygotic.

The dozen studies included in the meta-analysis were published from 1941 to 1999 and conducted by researchers mainly in Europe or the United States.

The authors of the meta-analysis are quick to note that the quality of the methods used in the 12 studies "was not uniformly high." For example, most studies "did not include several critical features (blinding or a standardized diagnostic approach) that are generally viewed as central to the interpretability of twin studies of medical disorders." Sullivan noted, however, that several of the studies were completed before these standards were recognized.

To gain the maximum benefit of the largest sample size, Sullivan and his co-authors included the lower-quality studies in the analysis and calculated whether they yielded a different estimate than if they used only the higher-quality twin studies.

Heterogeneity Was a Natural

In addition to problems with methodology, Sullivan noted, the 12 studies were statistically heterogeneous.

His group calculated statistical point estimates for both genetic and environmental components for each of the 12 studies. Genetic component estimates ranged from about 25 percent to 95 percent, while environmental components ranged from close to zero up to about 70 percent. This wide heterogeneity among the studies created concern over the significance of the overall estimates derived by the meta-analysis.

Remarkably, regardless of the quality of methods used in the original twin studies, and in spite of the high degree of heterogeneity, Sullivan and his colleagues found that both nature and nurture remained consistent.

"Critically, when we compared the methodologically superior studies with the methodologically inferior studies," the researchers pointed out, "we found similar point estimates for additive genetic effects (77 percent vs. 78 percent) and common environmental effects (17 percent vs. 14 percent)."

The high degree of heterogeneity could likely have resulted, the authors concluded, from differences in the study samples, including differences in male-female or monozygotic-dizygotic ratios.

X + Y = Schizophrenia

"However, it is also possible," they suggested, "that there exists true variation in the etiology of schizophrenia during the decades spanned by these studies or across the different countries and ethnic ancestries of the individuals in these studies."

Indeed, season of birth, prenatal exposure to viral infections, and maternal food supply—all of which have been linked to schizophrenia risk—would be expected to vary significantly across the 12 studies.

Sullivan and his co-authors concluded that while schizophrenia is overwhelmingly an inherited disorder, the environmental component of its development is highly likely to occur early in life, which would be

please see ***Schizophrenia*** *on page 27*

Traumatic Brain Injury Patients Face Multiple Psychiatric Sequelae

Major depression following traumatic brain injury is associated with reduced volume in the lateral aspects of the left prefrontal cortex.

BY MARK MORAN

Major depression is a frequent complication of traumatic brain injury (TBI) and is associated with psychiatric and neurological symptoms that hinder recovery.

Patients with major depression following TBI frequently exhibit comorbid anxiety and aggressive behavior, as well as executive dysfunction, poorer social functioning, and reduced left prefrontal gray matter volumes, according to Ricardo Jorge, M.D., and colleagues at the University of Iowa department of psychiatry.

The results of their prospective case-control surveillance study to determine the clinical, neuropsychological, and structural neuroimaging correlates of major depression occurring after TBI appeared in the January *Archives of General Psychiatry*.

In the study, 91 patients with traumatic brain injury were compared with 27 patients with multiple traumas but no evidence of central nervous system injury. Patients' conditions were evaluated at baseline and at three, six, and 12 months after the traumatic episode. Psychiatric diagnosis was made using a structured clinical interview and *DSM-IV* criteria. Neuropsychological testing and quantitative magnetic resonance imaging were performed at the three-month follow-up visit.

Of the 91 patients with TBI, 47 (51.6 percent) developed a mood disorder during the first year after injury, compared with six (22.2 percent) of the 27 patients with multiple traumatic injuries but without central nervous system involvement. Thirty patients (33 percent) presented with major depressive features, nine (9.9 percent) had depression without major depressive features, and the remaining eight patients (8.8 percent) had manic or mixed features.

Of the 27 controls, two patients (7.4 percent) had major depressive disorder and four (14.8 percent) had depression without major depressive features.

The researchers found that major depression was associated with reduced gray matter volume in the lateral aspects of the left prefrontal cortex. Other studies of secondary depressive disorders have also found decreased metabolic rates in inferior frontal regions in patients with Parkinson's disease, Huntington's disease, and caudate stroke, the researchers noted.

They analyzed the effect of a history of anxiety or depressive disorders on frontal lobe volumetric measures and found no significant differences between patients with a history of depressive or anxiety disorders and patients without a history of psychiatric illness.

"We can also hypothesize that social deprivation and unemployment can be associated with prefrontal cortex changes," Jorge and colleagues said. "However, unemployed patients did not show significant reductions in prefrontal volumes. In fact, patients with and without major depression who were unemployed had higher prefrontal volumes than their employed counterparts. Thus, there is no evidence to support the idea that asymmetric differences in frontal lobe volume pre-existed the brain injury, and we believe that the decreased left frontal lobe volume is the result of resolving traumatic lesions approximately three months after the TBI occurred."

Constantine Lyketsos, M.D., chair of APA's Corresponding Committee on Psychosomatic Medicine, said in an interview with *Psychiatric News* that the public health burden of traumatic brain injury is substantial and that the study by the Iowa researchers underscores the importance of collaboration between specialists in neurology, rehabilitation medicine, and psychiatry.

"There are hundreds of thousands of new head injuries of moderate severity or greater every year," he said. "Most of the time, people with head injuries recover and live with the consequences of brain damage, including psychiatric disorders that make recovery harder."

Lyketsos is a professor of psychiatry and behavioral sciences and co-director of the division of geriatric psychiatry and neuropsychiatry at Johns Hopkins University School of Medicine in Baltimore.

This study was supported in part by grants from the National Institute of Mental Health.

The study, "Major Depression Following Traumatic Brain Injury," is posted online at <http://archpsyc.ama-assn.org/ cgi/content/full/61/1/42>. ■

Parents of Autistic Children Forge Research Partnerships

The rate of diagnosed autism has nearly doubled in the last decade, fueling public health concerns, and the federal role in autism has expanded in partnership with parent-led advocacy groups.

BY CHRISTINE LEHMANN

Autism typically strikes preschool-age children, changing forever their lives and those of their families. One parent described the onset of autism as an "unwanted intruder who stole [her] son's mind and personality and left his bewildered body behind."

Jon Shestack, representing Cure Autism Now (CAN), a parent-led organization to advance biomedical research, spoke at the first national summit on autism organized by federal health and education agencies. The conference was held last November in Washington, D.C.

A decade ago, according to Shestack, few scientists were devoted to autism research in the entire country and funding was scarce.

"To accelerate the pace of autism research, several parents including us formed CAN in 1995 about the same time psychiatrist Eric London, M.D., and his wife, Karen, formed the National Alliance for Autism Research," said Stestack.

The Londons' son, Zachary, is autistic, and the couple was frustrated by the slow pace of autism research and lack of funding.

Both CAN and NAAR have raised millions of dollars to fund pilot research projects and advance awareness of the disorder. Their efforts are paying off.

Thomas Insel, M.D., director of the National Institute of Mental Health, who introduced Shestack at the summit, said, "He has led the charge in waking us scientists up to the importance of this disorder as a public health problem."

The rate of diagnosed autism cases has nearly doubled in the last decade from 1 in 500 children to 1 in 250 children. Scientists consider autism to be a spectrum disorder with symptoms ranging from mild to severe.

CAN initiated the Autism Genetics Resource Exchange, which will be shared with several research teams in the new collaborative Autism Genome Project announced at the summit. The project is the largest research collaboration ever assembled to determine the genes associated with the complex autism-spectrum disorders.

NAAR will collaborate on the genome project with the NIMH, National Institute of Child Health and Human Development (NICHD), National Institute of Neurological Disorders and Stroke, and National Institute of Deafness and Other Communication Disorders, according to NAAR Chair Prisca Chen Marvin.

The other research teams participating in the Autism Genome Project are affiliated with the Autism Genetics Cooperative, the International Molecular Genetic Study of Autism Consortium, and the Collaborative Programs of Excellence.

NAAR announced that it has committed $2 million to the project, and the four research institutes collectively committed $2.5 million.

"By pooling our resources and working together, we increase our chances of creating significant breakthroughs in the next five to 10 years that can improve the lives of families affected by autism," said Marvin at the summit.

"Unraveling the complex genetics of autism-spectrum disorders will require the kind of statistical power afforded only by pooling of DNA samples and data from ever larger numbers of affected families," said Insel at the summit.

Marvin announced another collaborative project with NICHD at the summit. The multisite High Risk/Baby Sibling Autism Research Project focuses on early diagnosis of autism-spectrum disorders and identifying biological and behavioral markers. The population under study is at high risk for developing autism: the infant siblings of children with autism. NAAR, which funded pilot studies for the last five years, has committed $700,000 to the new collaboration with NICHD.

Information about the two NAAR/NIH collaborative research projects is posted online at <www.naar.org/news/render_pr.asp?intNewsItemID=149>. ■

Schizophrenia

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consistent with current theories that schizophrenia arises from a neurodevelopmental etiology.

"The environments of members of twin pairs tend to diverge over time," they stressed, noting that the environment is "most similar in utero and in the immediate postnatal period, with increasing divergence over infancy, childhood, adolescence, and adulthood."

Their results, Sullivan and his co-authors said, "provide a component of a unifying empirical basis for supporting the rationality of searches for underlying genetic and common environmental etiological factors."

An abstract of the report is posted online at <http://archpsyc.ama-assn.org/cgi/content/abstract/60/12/1187>. ■

Achievement Awards

APA's Psychiatric Services Achievement Awards Committee is soliciting applications for the 2004 Achievement Awards competition. The committee is looking for two innovative and outstanding programs for mentally ill or disabled people that have been in operation for two or more years, have overcome obstacles, and can serve as a model for other communities. The deadline is February 23.

An application and additional information can be obtained online at <www.psych.org/psych_pract/awards.cfm> or from Mary Ward by phone at (703) 907-8592 or by e-mail at mward@psych.org. ■

Women Cite Depression As Barrier to Job Success

Depression may be the culprit behind many sick days and workplace errors, according to a survey of working women who have experienced its symptoms.

BY EVE BENDER

Women who have experienced depression rate it as the primary barrier to success in the workplace, according to a survey by the National Mental Health Association (NMHA) and the American Medical Women's Association.

According to the findings, depression or symptoms of depression interfered with work by increasing absenteeism and hampering job performance.

Researchers from Russell Marketing Research recruited a sample of 751 women from a national sample of more than 3,000 women who were screened for employment status and past or current depression with the Center for Epidemiological Studies Depression Scale.

Those chosen to participate in the survey had to be employed and report experiencing or having experienced symptoms of depression in the past.

Researchers conducted telephone interviews with the 751 women last April and May. They asked a variety of questions on such topics as work performance, treatment, and stigma.

Of those selected to participate in the survey, 501 women had been previously diagnosed with depression, but 250 women had never been formally diagnosed with the disorder.

A little less than half of the sample (45 percent) reported currently experiencing severe symptoms on a continuous basis over time, 27 percent reported experiencing mild symptoms, and 28 percent reported experiencing few or no symptoms at the time of the survey.

Among women who had been previously diagnosed with depression, 83 percent reported that depression was a leading barrier to success in the workplace and ranked it ahead of child- and elder-care responsibilities, sexual harassment, and gender discrimination.

Depression interfered with work in several ways, according to those surveyed. Almost three-quarters of the sample reported that depression caused them to be quiet and reserved. Almost as many (64 percent) said it caused them to be unmotivated at work. A total of 57 percent of women surveyed said they were more prone to job-related mistakes due to a lack of sleep.

Almost half (45 percent) of the sample said they had difficulty making it to work. The average number of days that depressed women are absent from work a year is twice as high as that for women workers in general (10.6 days versus five days). The number of work days lost to depression is linked to severity of symptoms—2.7 days a year for women with minimal or no symptoms to 9.5 days for women with mild to major symptoms.

Three out of 10 women reported having quit or lost a job while depressed, mainly due to symptoms of depression, according to the study.

Of the 501 women diagnosed with depression, 64 percent were taking a psychotropic medication at the time of the survey, and 58 percent were taking medications and undergoing psychotherapy.

Of the women who were diagnosed with depression, just half (47 percent) sought help "right away," according to the survey. Reasons for not seeking help immediately ranged from thinking they could handle the symptoms on their own to viewing depression as "something you have to live with" or viewing the symptoms of depression as a sign of weakness.

"Although the stigma associated with depression is decreasing, it continues to be a major factor in preventing women from seeking treatment," said Lea Ann Browning McNee, senior vice president of public affairs and community development at the NMHA, in a press release.

The study was funded by Wyeth Pharmaceuticals.

More information about the study, "Depression Among Working Women Number One Barrier to Success," is posted online at <www.nmha.org/newsroom/surveys.cfm>. ■

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Childhood Anxiety May Presage Development of Adult Depression

As early as age 9, children who later experience depression rate themselves more anxious and depressed than their peers.

BY MARK MORAN

Long-term research that has followed children into adolescence and early adulthood is beginning to yield developmental pathways that may allow early recognition of children at risk for depression and mood disorders.

Two studies appearing in the December 2003 *American Journal of Psychiatry* highlight the importance of internalizing behaviors in early childhood, as well as familial characteristics and other factors, in the later development of depression and anxiety.

One report looked at childhood and adolescent predictors—up to age 15—of major depression in the age range of 18 to 26, a period defined by the researchers as the "transition to adulthood."

They followed 354 participants in a single-age cohort. Data were collected from multiple informants, including mothers and participants, at seven major time points: ages 5, 6, 9, 15, 18, 21, and 26.

During the ages 18 to 26, 82 participants (23.2 percent) experienced major depression. Statistical analysis relating data collected during the period up to age 15 to major depression in the later stage showed family violence, family composition, internalizing problems during adolescence, and low family cohesion to be the most important contributing factors.

Internalizing problems were reported by having the children complete the 20-item Youth Report and having mothers fill out the Child Behavior Checklist. These problems include withdrawn behavior, somatic complaints, and depression and anxiety.

As early as age 9, the respondents who later experienced depression rated themselves more anxious and depressed than their peers. At age 15, both teens and mothers reported those in the depression group as having more internalizing behavior problems.

"The most important finding is that there are quite robust indicators in mid-childhood indicative of later major depression," study author Helen Z. Reinherz, Sc.D., told *Psychiatric News*. "By the time a child reaches adolescence, there are strong indications in the family and in the child's view of the family that can be very helpful in identifying these children."

She is a professor and principal investigator in the Simmons Longitudinal Study at Simmons College in Boston.

She added that the fact that children and teens can express themselves in a self-report format also bodes well for early identification and treatment.

"These ways of perceiving themselves and their families can enlighten caretakers and physicians about the child's mental health status," she said. "A teen can assess his or her own sadness and anxiety."

In a second report, Dutch researchers looked at parent reports of behavioral and emotional problems obtained using the Child Behavior Checklist for children and adolescents aged 4 to 16 from the Dutch general population. At follow-up 14 years later, lifetime mood and anxiety diagnoses were obtained from 1,580 subjects using a standardized *DSM-IV* interview.

Statistical models were used to predict incidence of mood and anxiety disorders from childhood problems and demographic variables.

Study results showed that mood disorders were significantly predicted by high scores on the anxious/depressed scale and internalizing (withdrawn, somatic complaints, and anxious/depressed) scores. Anxiety disorders were significantly predicted by the social problems scale and the "externalizing composite," which includes delinquent and aggressive behavior. Anxiety disorders predominantly started in childhood and early adolescence, while the incidence of mood disorders increased sharply in adolescence and young adulthood.

APA Trustee-at-Large and child psychiatrist David Fassler, M.D., who reviewed the reports, said they both "give us helpful information on how childhood behaviors can predict risk for adult psychiatric disorders."

He added, "So often we see kids at a particular point in their life, and what we are seeing is a cross-section. This research helps us to develop a more long-term perspective. If kids are at risk, I want them and their parents to recognize the signs as early as they can."

"Childhood and Adolescent Predictors of Major Depression in the Transition to Adulthood" is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/160/12/2141?>. "Stable Prediction of Mood and Anxiety Disorders Based on Behavioral and Emotional Problems in Childhood: A 14-Year Follow-Up During Childhood, Adolescence, and Young Adulthood" is posted at <http://ajp.psychiatryonline.org/cgi/content/full/160/12/2116?>. ■

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Risk Management Resolutions For the New Year

It's still not too late to make your annual resolutions. The risk management department of Professional Risk Management Services (PRMS) has developed six practice resolutions that any psychiatrist can make now to reduce potential professional liability risk. Part one of this article appeared in the January 16 issue. Part two addresses the last three risk management resolutions.

4. Terminate Treatment With Patients Appropriately

A psychiatrist owes certain legal and ethical duties to patients. To know to whom those duties are owed, it must be absolutely clear to the psychiatrist and to all relevant parties exactly who is and who is not a patient. Clarity in this area will reduce the risk of allegations of abandonment and malpractice.

• *Follow up with "no-show" patients.* The most frequently encountered area of uncertainty is the "no-show" patient. The psychiatrist should follow up on missed appointments to ascertain the patient's intention with regard to continuing treatment. In some instances, a follow-up letter might be sent. This advice applies to initial appointments as well, particularly if the new patient seemed to have an urgent reason for making the appointment. It may seem onerous or even counterintuitive to take such steps in light of the patient's no-show, but if an allegation of abandonment or malpractice were to be made, the psychiatrist likely will be on solid ground having documented the steps taken to ascertain the patient's intent (that is, having attempted to meet the patient's clinical needs).

• *It is risky to terminate treatment with a patient who is in crisis.* It can be extremely risky to terminate treatment with an outpatient who is in crisis. Ideally, the psychiatrist should continue treating until the crisis is resolved. If the patient's condition requires hospitalization, the psychiatrist may terminate safely while the patient is hospitalized; the psychiatrist should inform the patient and the inpatient clinicians that he or she is no longer the patient's psychiatrist and will not be available upon discharge. Participants of the Psychiatrists' Program, the APA-endorsed Psychiatrists' Professional Liability Insurance Program., who wish or need to terminate with patients who are in crisis should contact the Risk Management Consultation Service to discuss questions and concerns.

• *Do not assume you have been "fired."* When a patient "fires" his or her psychiatrist, the psychiatrist should assess whether the patient is in crisis. If the patient is not, a formal termination letter should be sent to the patient confirming that the psychiatrist-patient relationship has been terminated and that the psychiatrist is no longer available to the patient. If the patient is in crisis, the psychiatrist may need to remain involved until further action has been taken to assess and resolve the situation. Program participants in this situation should call the Risk Management Consultation Service to discuss questions and concerns.

5. Maintain Clear Boundaries

Boundary violations are stereotypically thought to refer only to sexual activity with a current or former patient. In fact, boundary violations occur in varied and subtle forms. Furthermore, not all boundary violations are created equal; some violations are more serious and potentially damaging than others. Program participants should contact the Risk Management Consultation Service if with any question about potential boundary violations.

• *Do not undertake any course of action that would tend to exploit or hinder the psychiatrist-patient relationship.* This means that, for example, the psychiatrist must not enter into a nontreatment business relationship with a patient, must not enter into an employment relationship with the patient, must not loan money to or borrow from a patient, and must not develop a social relationship with the patient outside of treatment. Exceptions may apply in rare circumstances.

• *Do not barter services for treatment.* If the patient if unable to meet the financial obligations of treatment, the psychiatrist must either structure a workable payment schedule or refer the patient to other resources.

• *Be mindful of the potential for boundary issues to arise in any setting.* Not all boundary violations appear obvious from the outset. Indeed, many situations begin quite innocuously. Psychiatrists should remain mindful that boundary violations have the potential to appear in any setting.

6. Be Nice

An amazing number of lawsuits arise simply because a patient becomes angry with his or her psychiatrist. Basic politeness and a good "bedside manner" on the part of the psychiatrist can go a long way toward reducing potential liability risk.

• *Engage in communication and informed consent.* A significant part of being nice includes communicating relevant information promptly and effectively to the patient and seeking the patient's informed consent to treatment. Psychiatrists should remember that informed consent is a process. As a patient's situation or treatment alternatives change, the patient should be consulted and consent renewed. The informed consent process also helps prevent unrealistic patient expectations, a major source of liability risk.

• *Be honest.* The act of formally apologizing when a potential error comes to light is a highly controversial issue, not just in psychiatry but in medicine in general. Expressing heartfelt empathy about a particular outcome may reduce risk for the psychiatrist by strengthening the psychiatrist-patient relationship. However, it is not clear whether the additional acts of accepting blame or admitting error further these goals. Program participants who are facing an adverse event should contact PRMS and ask to speak to the claims examiner or litigation specialist for their state.

• *Practice a good "bedside manner."* Even during a turbulent period, such as terminating with an especially difficult patient, the psychiatrist should try to project a bedside manner that makes clear that the patient's care comes first.

The full version of this article and related multimedia presentation are available online to participants of the Psychiatrists' Program in the "For Participants Only" section at <www.psychprogram.com>. If you are not insured with the Program, a complimentary copy of this article can be obtained by calling (800) 245-3333, ext. 389 or e-mailing TheProgram@prms.com.

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Good Risk Management Habits

1. Practice good medicine
2. Document
3. Safeguard patient confidentiality
4. Terminate treatment with patients appropriately
5. Maintain clear boundaries
6. Be nice

professional news

CMHCs

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stance abuse and chronic medical problems. People needed so much more in the way of treatment than was envisioned."

Even more important, perhaps, was the closing and downsizing of state psychiatric hospitals.

In 1955 a patient admitted to a state hospital stayed six months. By 1977 the average stay was three weeks.

"The bold new CMHC approach had little time and too meager resources to test its mettle before being overwhelmed. . .by the urgent needs of patients with chronic mental illness," wrote Henry Foley, Ph.D., and Sharfstein in *Madness and Government.*

The interface with the community turned out to be more complicated than was anticipated.

Engel said, "In some respects, CMHCs were set up like road commissions, rather than entities offering health care. In Michigan, county commissioners select members of CMHC boards, who are not required to have expertise about mental health or management issues."

The result, often, is trouble for the medical director if there are disputes about clinical issues and a general lack of educated oversight of the CMHC's operations.

Stewart said, "Psychiatry made assumptions about how services should be rendered and what the community needed. When protests occurred about those assumptions, we were not prepared for the battle and pulled back."

None of the discussants, however, argued for an abandonment of the CMHC concept.

Both Engel and Sharfstein urged a closer integration of primary and mental health care in a revised model.

Engel said, "We need a new approach in which psychiatrists deliver care in primary care settings."

He also noted that APA had been extremely helpful by developing model guidelines for psychiatric practice in CMHCs. Those guidelines, which were published in the *Manual of Psychiatric Quality Assurance* (APPI, 1992), include job descriptions for the CMHC medical director and staff psychiatrist and for evaluation and treatment of patients.

Appelbaum warned, "It would be a big mistake to walk away from everything that is good about the centers. I don't see another conceptual model out there that addresses the basic problems of service delivery as well as CMHCs."

Sharfstein agreed, arguing, "CMHCs were a concrete expression of the right of every American to quality mental health care. This vision is even more valid today because psychiatric treatment has become more effective. We should return to what was so right about this vision and implement it with all we have learned in the last 40 years." ■

Medical Errors

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• *Communicate with other treatment providers:* Communicate with other physicians about all the medications that are being prescribed and about signs, symptoms, and responses to the medications.

• *Obtain consultation from an experienced colleague:* Obtain professional consultation or a referral to a physician with specialized training and expertise when appropriate.

• *Handwriting and prescription pads:* Writing on prescription forms and drug orders must be legible. Consider writing in numerals and in longhand, as on a check. Use tamper-resistant prescription pads with security devices. Store prescription pads in a secure place when not in use.

• *Stay current on medication information:* Participate in continuing education programs. Educate yourself through discussion with colleagues and through relevant literature. Review drug-manufacturer alerts.

Step 4: Implement the Strategy

It is not necessary to try to change everything at once. Start with selected strategies that have the most potential to impact the most significant patient-safety issues identified. Focus on improving systems and processes that support patient safety.

Computerization offers great potential to reduce adverse medication events. Appropriate computer programs may be used to type and transmit prescriptions, access the latest information, communicate securely with others, promptly follow up on laboratory tests and results, and provide alerts about potential medication interactions.

Step 5: Evaluate the Strategy

After a reasonable trial, decide whether the chosen strategy works, then modify it or implement another strategy as needed. Share your efforts with colleagues. ■

ASTRAZENECA SEROQUEL

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Psychiatric Leadership

In her letter in the December 5, 2003, issue, Dr. Kalpana Prasad addresses the importance of having one's physician-leadership role acknowledged, as well as our trademark commitment to patients' well-being. The question at large, however, is what has led to this perceived threat to our leadership role?

The answer is not insurers or other mental health professionals and certainly not patients, but we ourselves. I believe we have systematically given up authority, leadership, and advocacy responsibilities and now cry "foul" when terms are dictated to us. We have invented the term "med checks" and have deflected psychotherapy to the therapist next door, and may even be preaching this practice to the next generation of psychiatrists. We have not effectively objected to the sole role and label of "prescription/refill providers," and yet we seem to feel threatened by mental health professionals telling us what's best for our patients.

At the core of the leadership issue is what defines a psychiatrist. One cannot rely on the license to prescribe medications, examine patients, and order investigations as defining features, as physicians are no longer the exclusively privileged. As with psychologists in New Mexico, it is just a matter of time before other counselors and allied health professionals claim eligibility to write prescriptions for the patients with whom they work. And I believe it is also just a matter of time before some antidepressants become available without a prescription. In several developing countries, most pharmacies sell psychotropics without a formal prescription, yet psychiatrists or other physicians there do not perceive a threat to their profession or leadership role.

The definition of leadership in psychiatry goes beyond graduation from medical school, psychiatry residency, and a license to practice medicine and prescribe pills. Leaders are distinguished by their untiring advocacy, responsibility to patients, and support for patients' access to care. Physicians are distinguished by their dedication to the study, safe application, and advancement of scientific and medical knowledge and their sacred regard for the doctor-patient relationship. Psychiatrists take pride in their holistic and biopsychosocial approach to patients' well-being. The moment we shirk these commitments, we diminish our effectiveness as leaders, physicians, and psychiatrists.

PRAVEEN P. FERNANDES, M.D.
Omaha, Neb.

Readers are invited to submit letters not more than 500 words long for possible publication. Submission of a letter implies consent for publication unless otherwise indicated. All letters are subject to editing to meet style, clarity, and space requirements. Receipt of letters is not acknowledged. Send submissions to Letters to the Editor, *Psychiatric News,* APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209; fax: (703) 907-1094; e-mail: pnews@psych.org.

Opinions expressed in letters do not necessarily reflect the views of APA or the editors. Clinical opinions are not peer reviewed and thus should be independently verified.

Illogical Argument

The pharmaceutical industry has a new approach to assist financially strapped state Medicaid authorities. Eli Lilly and Co., the manufacturer of the largest-selling antipsychotic (Zyprexa), is funding a program in Missouri developed by Comprehensive NeuroScience Inc. that uses a computerized review of Medicaid-funded prescriptions to identify, among other factors, when physicians are prescribing two or more atypical antipsychotics to the same patient ("Medicaid Patients Benefit From Best-Practice Education Project," November 21, 2003). The physician is then sent a letter listing which medications are being prescribed along with educational materials about the lack of empirical support and potential dangers of polypharmacy.

This program reminds me of how parents used to evoke the image of "starving Chinese villagers" to shame their children into not wasting their food. Polypharmacy can be clinically unwarranted and fiscally wasteful. But just as children not finishing their suppers has almost nothing to do with world hunger, so polypharmacy has almost nothing to do with rising medication budgets. The motivation for such a program does not grow out of the Medicaid authority's desire to improve prescribing practices or the pharmaceutical industry's wish for medication expenditures to be reduced. Raising the current reimbursement for a medication-management visit in Missouri from $13.50 might do much more for improved prescribing practices. If Lilly wants to reduce the budget pressures on states, for example, it could lower the cost of Zyprexa to the Canadian price.

Missouri is the "Show Me State." Whether this particular program will reduce antipsychotic polypharmacy or save money is an empirical question. Possibly, just as the child might waste less food when reminded about starving children, so the chided physician may reduce polypharmacy. In itself this might be good. But the more important impact of such a program, like the parents' admonition, is to evoke guilt and shift responsibility. From a public-relations perspective, the program allows the pharmaceutical industry and the Medicaid authorities to join in shifting blame for escalating medication budgets to physicians.

It took me years to figure out that all those mashed potatoes I never finished had nothing to do with some child starving in the Third World. Likewise, the problem of runaway medication budgets is not due to poor prescribing by physicians, but rather to the pharmaceutical industry's pricing policies.

DANIEL LUCHINS, M.D.
Chicago, Ill.

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cerning graduate medical education and national health policies.

The RFS has been very successful at advocating for change in areas such as resident work hours, collective negotiations, resident contracts, working conditions, public health and safety, and resident representation within hospitals and on residency review committees.

The meetings of the AMA-RFS are long and involve a lot of work, but resident leaders are dedicated, and they work hard toward addressing issues of significance to residents and fellows. The group meets twice a year, in June and December, and staff provides several services to members. Information about the section's activities, as well as policies and opportunities of interest to residents, is posted on the AMA's Web site at <www.ama-assn.org/go/rfs>. The site offers a blast e-mail service that sends information to subscribers once a month. To subscribe to the blast e-mail, send your name, the name of your medical school, and your year of graduation to rfs@ama-assn.org.

The RFS also publishes information each month in the "Code Blue" column in *Resident and Staff Physician*. The AMA provides special financial programs to assist residents, including these:

- Educational loan consolidation program
- Home-mortgage and home-equity loan programs
- VISA credit card
- Car rental program
- AMA-Consulting Link (consulting/attorney referrals)

The RFS Assembly heard 19 items of business, on diverse topics such as the National Resident Matching Program, antitrust litigation, house-staff exemptions from paying the FICA tax, physician privacy for training-related information, medical tort litigation reform, diversity in the medical profession, patient satisfaction and professional regulation, and many others.

The AMA-RFS also submitted four resolutions to the AMA House of Delegates for consideration, addressing issues of workplace safety of health care professionals, medical errors and physician standards, privacy protection of the physician information held by the ACGME, and excessive telephone wait times for physician appeals of managed care decisions.

The first two resolutions were reaffirmed by the house, but it recommended against consideration of the other two. All reports and resolutions considered at the interim meeting can be downloaded now from the AMA's Web site at <www.ama-assn.org/ama/pub/category/11669.html>.

I hope this article has stimulated you enough to explore the AMA-RFS's Web site and become members of APA and the AMA if you have not done so already. You are a resident, and your input matters. We are instrumental in shaping the future of our field. Let us start now. If you have any questions or need information about how to become involved, e-mail me at Manisha.Punwani@umassmed.edu or Angela Harper, M.D., at a_d_harper@yahoo.com. ■

Medicare

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cited a recent controversial decision by the government to approve intracardiac defibrillators for a larger population of Medicare patients.

But he noted that there is in fact evidence that "these defibrillators are often put into people who really won't benefit from them, and in a sense aren't allowed to die a natural death."

He added, "But this defibrillator is keeping them alive, and they die of dementia or something more painful."

Berenson said, "Why not say, 'Let's approve these defibrillators but let's identify centers of excellence as the places where beneficiaries go to get true informed consent about whether this is in their best interest.' " In this way, he said, the government would be managing how it purchases expensive health care services.

The Webcast interview can be read online at <http://kaisernetwork.org/health_cast/uploaded_files/120403_ha_medicare.pdf>. The Lieberman article is posted at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w3.603>. The Berenson article is posted at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w3.586>. ■

Women

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through the Health Awareness Workshop program at the University of Louisville.

Dickstein is a professor of psychiatry at the University of Louisville School of Medicine and an associate dean for faculty and student advocacy.

In 1966, after six years of working as a grade-school teacher in Brooklyn to support her husband while he attended medical school, Dickstein entered medical school.

As one of the few women medical students in her class at the University of Louisville, Dickstein found herself juggling academic life with the responsibilities of raising three sons.

According to Dickstein's biography, "her husband, a pathologist, helped keep her close to her sons, even bringing them to visit while at the hospital. . .during her residency."

Dickstein told *Psychiatric News* that she is "honored and humbled" to be a part of the National Library of Medicine exhibit. In her work, she said, she helped medical students to realize that "we have to first take care of ourselves in order to take care of our patients."

The exhibit, she said, will inspire young people of all backgrounds when they learn the women in the exhibit overcame many barriers and "worked hard to become physicians and improve health around the world."

"Changing the Face of Medicine" will run until April 2005. Information, images, and videotaped interviews of the women featured in the exhibit are posted online at <www.nlm.nih.gov/changingthefaceofmedicine>. ■

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MH Crisis

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of care for a psychiatric patient in a hospital.

Medicaid law prohibits federal reimbursement for inpatient psychiatric care for patients between the ages of 21 and 64, resulting in further costs for local governments.

APA member Jon Gudeman, M.D., was quoted in the *Milwaukee Journal* article as saying, "We have a crisis all right. The pendulum has swung too far. We now have too few beds to effectively treat the sickest of our patients."

He is the former medical director of the Milwaukee County Mental Health Complex and is now director of the Center for Psychotherapy at Columbia-St. Mary's, Columbia Campus.

A front-page series titled "Michigan's Mentally Ill: Crisis in Care" in the *Detroit News* last July led to joint hearings of the Senate's Committee on Health Policy and Subcommittee on Community Health of the Appropriations Committee about problems in the state's mental health system *(Psychiatric News*, November 7, 2003).

On December 15 Gov. Jennifer M. Granholm (D) appointed a mental health commission that is "designed to recommend sweeping changes in both the delivery of service and effectiveness of Michigan's mental health network."

The 33-member commission includes three members of the Michigan Psychiatric Society (MPS): Thomas Carli, M.D., a clinical associate professor of psychiatry at the University of Michigan; Michele Reid, M.D., immediate past president of MPS and medical director of the Detroit-Wayne County Community Mental Health Agency; and Rajiv Tandon, M.D., a professor of psychiatry at the University of Michigan.

The Flinn Foundation of Detroit has contributed $220,000 to support the commission's work.

Ten states have convened temporary mental health commissions, and three have established permanent standing bodies to analyze the way states deliver mental health services, according to the press release announcing the Michigan commission.

In Nebraska, also on December 15, Gov. Mike Johanns (R) and Sen. Jim Jensen (R) released a plan developed by the state's two academic health science centers—the University of Nebraska Medical Center and Creighton University—that calls for the creation of the Nebraska Center of Excellence in Behavioral Health.

The center would recruit more students into behavioral health, increase access to services through tele-health and tele-education, and provide statewide training programs for clinicians.

The recent plan is part of a larger effort by Johanns to restructure the state's mental health system. He advocates closing two of the state's three public psychiatric hospitals in 2005 and has said that "not one regional center bed" will be eliminated before a substitute bed is established in a community-based setting, according to the January 4 *Omaha World Herald.*

The *World Herald* reported that a "pre-session survey of Nebraska lawmakers found that a significant number of lawmakers need reassurances that the state still will provide adequate care for people with mental illness."

Thirty lawmakers identified the mental health restructuring plan as one of the top five issues for the 2004 legislative session. ■

N.M. Governor

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The four psychiatrists told the governor that if patient safety is to be protected, psychologists must prescribe under medical supervision, just as nurse practitioners, physician assistants, and clinical pharmacists do in the largely rural state. In addition, educational requirements must be set high to maintain an appropriate and adequate skill and knowledge base.

Goin underscored that, with regard to psychologist-prescribing legislation, "the eyes of the nation are on New Mexico." She pointed out to the governor that more than 20 other state legislatures had considered and rejected bills granting prescribing privileges to psychologists.

> **"The governor heard what we had to say, and we came away feeling he really heard the importance of patient safety."**

Richardson acknowledged that although he "didn't like the bill," since it was enacted, it must be implemented. He directed his health policy advisor, who also attended the meeting, to inform the president of the medical board to "do the right thing," elaborating that he felt that education and training must be of high quality. He also agreed that medical board oversight was a high priority and noted that he would inform the medical board that there was no pressure on them to compromise their requirements.

"It was a very positive meeting," Scully told *Psychiatric News.* "Given the realities, [the governor] was very supportive."

Goin added, "The governor heard what we had to say, and we came away feeling he really heard the importance of patient safety."

Since the meeting, the governor's health advisor met with the president of the New Mexico Medical Board, communicating the governor's support for stringent standards and medical oversight. The medical board and psychology board must iron out a final set of regulations implementing the law, which would then undergo a public-comment period and legislative rules hearings prior to implementation. ■

Teen Drug Use

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Use of other drugs held steady between 2002 and 2003, however, and some even rose.

• About 5 percent of seniors used cocaine and 1 percent used heroin over the last two years.

• Nonprescription use of oxycodone showed insignificant increases for all grades between 2002 and 2003; In the 2003 survey, 1.7 percent of eighth graders, 3.6 percent of 10th graders, and 4.5 percent of seniors reported using the drug during the preceding year.

Although teen smoking dropped dramatically through the mid-1990s, those declines are losing momentum, Johnston noted. Among eighth graders, the prevalence of current smoking, defined as smoking one or more cigarettes in the preceding month, fell by only half of 1 percent last year, from 10.7 percent to 10.2 percent.

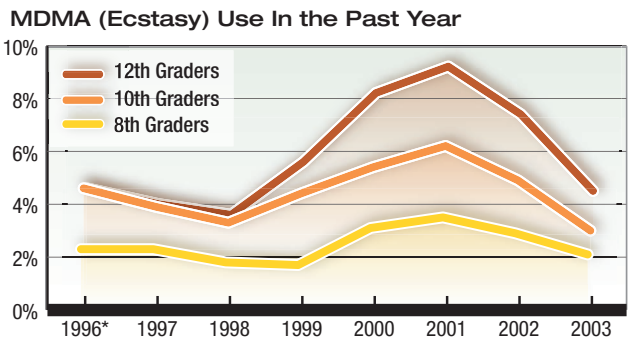
Cigarette use by 10th graders dropped from 17.7 percent to 16.7 percent, and for seniors, smoking rates dropped from 26.7 percent to 24.4 percent for the most recent year. "Even with [these] improvements," Johnston said, "we still have a quarter of our young people who are actively smoking by the time they leave high school, which is an unacceptably high rate for a behavior that so endangers their health and reduces their life expectancy."

Alcohol use for teens remained relatively steady over the past two years—almost half of seniors surveyed (47.5 percent) reported current alcohol use.

More information about the 2003 Monitoring the Future Survey is posted online at <http://monitoringthefuture.org/>. ■

Ecstasy Use Continues to Drop

Rates of MDMA use among high school students have dropped considerably from two years ago, when nearly 1 in 10 high school seniors reported using the illicit drug.



*1996 is the first year for which MDMA data are available
Source: 2003 Monitoring the Future Study, University of Michigan

Landmark Suit

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ceeded in convincing it to assign independent monitors to oversee how the state complied with Johnson's ruling.

Nine years later, the parties entered into an agreement to fulfill Johnson's terms, but Alabama officials continued to drag their collective feet. By January 2000 some improvements had been made, but the state hospitals were still a long way from meeting the judge's mandate. Alabama and federal officials were able at that time to agree on a settlement in which the federal government would terminate the monitoring program, and state officials promised in return to increase funds sufficiently to complete the patient-care and facility improvements. The agreement also obligated the state "to conduct interdisciplinary team meetings and to develop individualized treatment plans" for every patient in a state psychiatric hospital.

Hospital administrators were given nine months to hire consultants who would help them establish seclusion and restraint practices and revised discharge procedures. The agreement also provided for about 600 patients to be transferred from hospitals to community care.

Finally, on December 5, 2003, U.S. District Judge Myron Thompson, who replaced the late Judge Johnson on the *Wyatt* case, brought the protracted legal wrangling to an end. He ruled that Alabama officials have lived up to the terms of the 2000 settlement with the federal government. Gov. Bob Riley, who was present for Thompson's decision, stated, "We do not look at the end of the case as a diminishment of our responsibilities, but as more responsibility we have to shoulder ourselves."

The case "had a huge impact on the care of patients in state facilities, but not for the reasons anyone would have anticipated," explained forensic psychiatrist Paul Appelbaum, M.D. "As the odyssey of *Wyatt* suggests, courts had only limited success in forcing states to comply with orders to improve their facilities."

Appelbaum, a former APA president, is chair of the psychiatry department at the University of Massachusetts and director of its Law and Psychiatry Program.

"Moreover," he continued, "the criteria on which the courts focused tended to be those most easily measurable, as opposed to those most likely to improve the quality of treatment. But the fear of litigation after *Wyatt* stimulated many states to enter into consent decrees that required increased expenditures on state hospitals, or to undertake such efforts prophylactically. And *Wyatt* undoubtedly accelerated the closure of state facilities—clearly a mixed blessing. For better and for worse, *Wyatt* helped to change the face of American public-sector psychiatry." ■