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Clinical & Research News

FDA Poised to Intensify Suicide Warnings on SSRIs

The first in a two-part series, this article looks at the FDA's stand on the issue of SSRIs and the risk of suicide in children and adolescents. The concluding article will take a look at what the data actually show—or don't show.

BY JIM ROSACK

After a grueling, often emotional 7.5-hour hearing on February 2, a group of advisers from the Food and Drug Administration (FDA) told the federal agency to err on the side of caution: stronger warnings about the risk of suicidal thoughts and behaviors associated with antidepressant medications given to children should be communicated to physicians and the public as soon as possible.

In the end, the joint panel of the FDA's Psychopharmacologic Drugs Advisory Committee (PDAC) and Pediatric Subcommittee of the Anti-Infective Drugs Advisory Committee told the agency the very thing it least wanted to hear: while the panel applauded the agency's efforts and agreed that more complete data are needed for a definitive analysis of the issue, the "signal" of a link between SSRIs and suicidal ideation and behaviors is too alarming to wait for that analysis.

"Our sense is that we would like in the interim for the FDA to go ahead and issue stronger warning indications to clinicians," said Matthew Rudorfer, M.D., chair of the PDAC and director of treatment research at the National Institute of Mental Health's Division of Services and Intervention Research.

Rudorfer noted that a warning would not stop clinicians from prescribing antidepressants to appropriate patients, but would alert them to monitor patients closely for signs of self-harming or suicidal ideation or behaviors.

Historically, the agency has abided by the advice of its advisory panels, but is not legally bound to do so.

Thomas Laughren, M.D., team leader for the FDA's Division of Neuropharmacologic Drug Products, thanked the panel for its input and said the agency takes the panel's recommendation "very seriously." He noted that a warning would likely be issued "sooner [rather] than later."

As this article went to press, the FDA had not taken any new action on the issue.

Above all, last month's hearing was a daylong study in contrast, consisting of long scientific presentations of intricate detail on clinical trial data interspersed with impassioned testimony from family members of persons who had committed suicide while taking SSRIs. Reasoned discussions of the data and what they could—or could not—tell regulators were mixed with fervent pleas to issue warnings immediately, regardless of the scientific analysis.

A few people who testified begged the FDA to remove SSRIs from the market immediately. Many strongly urged the agency to stop "sitting on its hands," "stalling," and "protecting the pharmaceutical companies" and issue a strong, formal warning to American physicians and patients of the potential risk, just as British regulators had done last summer. Others urged the regulators not to restrict the use of what they said are clearly

please see ***SSRIs*** *on page 62*

APA Trustee-at-Large David Fassler, M.D., testifies that "APA is concerned that the publicity surrounding this issue may frighten some parents and discourage them from seeking help for their children."

Clinical & Research News

Antipsychotics' Diabetes Risk Prompts Call for Better Assessment

Monitoring patients on second-generation antipsychotics for signs of metabolic dysfunction must become part of basic clinical care.

BY JIM ROSACK

A new consensus statement confirms that the risk of significant treatment-emergent changes in glucose metabolism associated with second-generation antipsychotics (SGAs) requires careful assessment and continued monitoring. In addition, the statement says, the risk of metabolic abnormalities differs among the six available medications.

The consensus statement, released last month, was the product of a conference held last November that was led by the American Diabetes Association (ADA) and co-sponsored by APA, American Association of Clinical Endocrinologists, and North American Association for the Study of Obesity. The statement was published in the February *Diabetes Care*, an ADA peer-reviewed journal. APA members participating on the panel included John Kane, M.D., chair of psychiatry at Long Island Jewish Medical Center and the Dr. E. Richard Feinberg chair in schizophrenia research and a professor of psychiatry and neurology at Albert Einstein College of Medicine; and John Davis, M.D., the Gillman professor of psychiatry at the University of Illinois at Chicago.

Darrel Regier, M.D., Ph.D., head of APA's Office of Research and the American Psychiatric Institute for Research and Education, noted that the consensus panel statement, while consistent with emerging research, is not an official position statement of APA. Regier said that the Association's Council on Research has a work group that is developing recommendations for an APA position statement that will go into detail on the mechanisms affecting lipid and glucose metabolism and will include a discussion of treatment implications.

The eight-member panel heard presentations from 14 experts in psychiatry, obesity, and diabetes, as well as presentations from the Food and Drug Administration (FDA) and representatives of AstraZeneca, Bristol-Myers Squibb, Janssen, Lilly, and Pfizer, all of which market SGAs. The panel said it also reviewed the majority of the known peer-reviewed clinical literature on

please see ***Diabetes Risk*** *on page 64*

SGAs and Diabetes Warning Signs

Drug	Weight gain	Risk for diabetes	Worsening lipid profile
Clozapine	+++	+	+
Olanzapine	+++	+	+
Risperidone	++	D	D
Quetiapine	++	D	D
Aripiprazole*	+/–	–	–
Ziprasidone*	+/–	–	–

+ = increase effect; – = no effect; D = discrepant results.
*Newer drugs with limited long-term data.

Source: *Diabetes Care*, February 2004

Dozens of Medical Organizations Tell Congress to Pass Parity Law

Support is growing for the Sen. Paul Wellstone Mental Health Equitable Treatment Act, which would require group health plans that provide mental health benefits to do so without discriminating against care for mental illness.

Government News

BY MARK MORAN

APA, the American Academy of Child and Adolescent Psychiatry (AACAP), and more than 45 other medical specialty societies, as well as 50 state medical societies, have signed on to letters sent to every member of Congress in support of nondiscriminatory coverage for mental illness treatment.

The letters urge support for the Sen. Paul Wellstone Mental Health Equitable Treatment Act (S 486), introduced by Sens. Pete Domenici (R-N.M.) and Edward Kennedy (D-Mass.), and for a companion bill in the House (HR 953), introduced by Reps. Jim Ramstad (R-Minn.) and Patrick Kennedy (D-R.I.).

The bills would require group health plans that provide mental health benefits to do so without limits different from limits on medical and surgical benefits. If parity becomes law, health plans could not impose arbitrary durational limits on treatment or require patients to pay more out-of-pocket expenses for their mental health benefits. Businesses that employ 50 or fewer persons would be exempted.

Proof of Growing Collaboration

APA and AMA leaders say the support from the "House of Medicine" for nondiscriminatory coverage of mental illness is an extraordinary example of the growing collaboration between psychiatry and the rest of medicine.

"It's a milestone and a very powerful statement," said John McIntyre, M.D., chair of the psychiatry delegation to the AMA House of Delegates. "It shows that the issue of nondiscriminatory coverage has matured to the point where it is no longer only psychiatry's issue, but is all of medicine's issue."

He added that beyond the political import of the letters, the support of so many state and specialty societies was a statement to patients that the medical community views mental illness as it does any other type of illness. "It's a fundamental statement about how far we have come in our understanding of mental illness," McIntyre told *Psychiatric News*.

McIntyre was echoed by Jeremy Lazarus, M.D., vice speaker of the AMA House of Delegates and chair of APA's Council on Advocacy and Public Policy.

"The fact that we have been able to obtain such overwhelming support urging passage of the parity bill is another reminder of the strong collaboration we have with the rest of organized medicine," Lazarus told *Psychiatric News*. "It also indicates the understanding and importance that our other medical colleagues place on the fair treatment of the mentally ill and how important appropriate and timely treatment is. The support that we have received should improve the chances that the legislation will pass."

APA President Marcia Goin, M.D., also emphasized the landmark nature of the widespread support for nondiscriminatory coverage.

Speaking With One Voice

"The nation's medical and mental health communities speak with one voice in fighting for fair and equitable employer-provided mental health insurance," Goin said. "Our message to congressional leadership is clear: it's time for a floor vote on this urgently needed legislation. Not only have majorities in both chambers signed on as cosponsors of mental health parity, but this legislation, by affording people the care they need, would save the nation's economy billions of dollars in lost productivity. The time to act is now."

The letters, sent to Senate Majority Leader Bill Frist (R-Tenn.) and Speaker of the House Dennis Hastert (R-Ill.), were the result of a resolution passed with unanimous support by the AMA House of Delegates in June 2003. That resolution was introduced by APA and AACAP.

The letter was signed by specialty groups as diverse as the American College of Surgeons, American College of Emergency Physicians, American Medical Directors Association, and American Society of Plastic Surgeons.

It was also signed by 49 state medical societies and the medical society of the District of Columbia. Only the Kansas Medical Society declined to sign on because of a stated position in opposition to insurance mandates, McIntyre explained.

Countering the Kansas position, McIntyre stressed that nondiscriminatory coverage is not an insurance "add on" in the form of state mandates, but a fundamental principle about the right to health care.

The letters to Frist and Hastert noted that 243 House cosponsors and more than 300 national organizations support nondiscriminatory coverage and that President Bush called on Congress in April 2002 to enact mental health parity legislation for him to sign.

Two House committees held hearings last year on the parity issue, but the House has

please see ***Parity*** *on page 4*

Adrift in the Pacific With a Bengal Tiger

BY MARCIA GOIN, M.D.

There are differing schools of thought about the origins of aggression. Some postulate that an infant comes into the world with a template of aggression that is tamed by a nurturing environment. Others see the infant's psyche as a pure Petri dish. In their view, savage responses in human beings occur in reaction to negative life experience.

The allegorical novel *Life of Pi* by prize-winning novelist Yann Martel artfully describes an example of the latter hypothesis. The protagonist, Pi, through unusual circumstances, ends up adrift on the ocean sharing his lifeboat with several wild animals including a Bengal tiger. In time, as the others kill each other off, only he and the tiger, named Richard Parker, remain. Once shock and fatigue recede, Pi recognizes the imperative not only to feed himself, but also to get hold of food to train and keep Richard Parker at bay.

When swarms of flying fish swoop by, he easily catches one. Pi's struggle begins as he tries to gather the emotional fortitude to kill the fish:

"Several times I started bringing the hatchet down, but I couldn't complete the action. . . .I covered the fish's head with the blanket. Again my hand wavered in the air. The idea of beating a soft, living head with a hammer was simply too much. . . .

"I egged myself on until I heard a cracking sound. . . . I pulled back the folds of the blanket. The flying fish was dead. . . .

"I wept heartily over this poor little deceased soul. . . .I was now a killer. I was now as guilty as Cain. I was 16 years old, a harmless boy, bookish and religious, and now I had blood on my hands. . . .

"After that it was easier. . . .

"Lord, to think that I'm a strict vegetarian. To think that when I was a child I always shuddered when I snapped open a banana because it sounded to me like the breaking of an animal's neck. I had descended to a level of savagery I never imagined possible."

This episode describes with poignant eloquence Pi's descent into what he calls "savagery."

During the time I was reading *Life of Pi*, Brad Stein, M.D., gave a presentation at USC Grand Rounds on "A Mental Health Intervention for Schoolchildren Exposed to Violence." Sixth-grade students at two large middle schools in Los Angeles were asked about their exposure to violence. Remarkably, more than 60 percent of the children had substantial exposure, defined as being the victim or witness to violence involving a knife or gun, or having a Life Events Scale summed score greater than 6, consistent with exposure to three or more violent events. Many in the audience, like myself, were startled to learn the percentage of children who by the age of 12 had been witness to or experienced violence. What does this presage for their own potential for violence if affirming life experiences do not intervene to counterbalance their traumatic histories?

We have a major challenge before us to reach out and provide "countering experiences" for young people. Instead, programs of outreach to children are being drastically cut at the state and federal levels. After-school opportunities to engage in creative learning and special events are being eliminated. Instead of expanding, programs for health and education are being pitted against each other as targeted areas for budget cuts.

At this writing President Bush's proposed $2.4 trillion budget will not meet the needs of impoverished school children and won't come close to the needs of local school districts, which must meet the standards of the No Child Left Behind initiatives. Other sources of school funds will be cut, including 38 programs, such as those focusing on dropout prevention, guidance counselors in elementary schools, and increased parental involvement in poor communities.

California Gov. Arnold Schwarzenegger has proposed saving $20 million by eradicating the Children's System of Care Program, a successful operation that has touched the lives of countless poor and needy children. The program provides counties with dollars to develop and coordinate individualized services around those kids who are served by multiple agencies. In addition, parents of children with mental illness actively participate on the planning team to ensure that families are represented. The governor has also proposed to eliminate $5 million from the Early Mental Health Intervention program that targets children in kindergarten through third grade who have behavioral and emotional problems.

From psychiatric epidemiological research and empirical experience we know that violence, poverty, and disasters contribute to neuropsychiatric disorders. And we also know that violence perpetuates violence.

A society is judged by how it cares for its children. Tragically, America is failing this test. Outspoken advocacy is needed to protect our children and to vouchsafe the future of our nation. ■

Erratum

In the January 16 "From the President," Jonathan Marks was incorrectly identified as a reporter for the *News and Observer* in Raleigh, N.C. Marks, a barrister from London, is a visiting professor of law at the University of North Carolina Chapel Hill School of Law. He is well known for representing Nancy Olivieri, M.D., in the European Court of Justice in a case that raised a number of legal and ethical issues arising from the direct funding of clinical trials by pharmaceutical companies. He also recently wrote an article on direct-to-consumer pharmaceutical advertising, which is posted at <www.ncmedicaljournal.com/nov-dec-03/ar110311.pd>. ■

Department Keeps Track of APA History While Gearing Up for Future

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

The Melvin Sabshin Library and Archives is the APA department that serves as a bridge between APA's past and its future.

The Library and Archives fields more than a hundred requests for information and research services each month from APA members, staff, other health care providers, attorneys, reporters, historians, and other researchers. Whether it is hunting a quotation purportedly by Benjamin Rush, finding the number and distribution of psychiatrists by subspecialty in Michigan, determining the reliability and validity of the Global Assessment of Functioning Scale, tracking down a training video on tardive dyskinesia, identifying an expert consultant on lycanthropy, or simply completing a bibliographic citation—the answer can be found in the Library's extensive collection of print, multimedia, and electronic resources.

APA's Library also serves as a national resource for academic and medical librarians who call or e-mail when their own research hits a dead end. Occasionally callers are looking for specific quantitative psychiatric service standards or other mental health–related statistics that do not exist, and they are relieved that their search can be put to rest.

Far from making libraries and librarians obsolete, the Internet has created a new triage role for librarians to aid the victims of the information explosion. Members usually find the information they need through their local library resources and are quite savvy about using the Internet, so it tends to be the particularly tough questions or those specific to APA history and policy that are referred here.

Providing state-of-the-art library research and information services to members and supporting the research, educational, clinical, and publishing aims of APA departments and components are but two aspects of the Library's operations. The primary mission of the Library and Archives, of course, is to preserve the record of the Association and its subsidiaries (American Psychiatric Foundation, American Psychiatric Institute for Research and Education, and American Psychiatric Publishing Inc.) and to make APA's history accessible to members and the research community.

The Archives serves as the institutional memory of the Association and as a rich resource on the history of American psychiatry in general. One major project now under way is building an information infrastructure on the Internet providing access to documents, photographs, and oral history audio clips. Already the Library's Web site provides access to APA position statements from 1948 to the present, most resource documents, and the last several years of annual meeting and new research abstracts. Task force reports and amicus curiae briefs are next on the docket for text-digitization. "Finding aids" for the psychiatrists' papers and oral history collection are also available on the Web site, with the goal of making full-text manuscripts and transcripts available in the future.

The Library and Archives must look to the future as well as the past. Working papers and drafts of the various editions of the *Diagnostic and Statistical Manual of Mental Disorders* are a frequent topic of interest among doctoral students and faculty. A major challenge for the Archives over the next decade will be to preserve the record of the development of the *DSM-V,* which, for the first time with any edition, will largely be produced and revised online via electronic documents and e-mail communications.

The director of the Melvin Sabshin Library and Archives is Gary McMillan, M.A.L.S., M.S. He is assisted by Lucy Ozarin, M.D., M.P.H., distinguished life fellow, who volunteers one day a week. The department's annual budget is $109,573. ■

Association News

APA Organizes Elective for Medical Students On HIV and Mental Illness

With HIV spreading rapidly in minority communities in the United States, APA is recruiting medical students for a new elective that will provide a comprehensive look at the intersection of HIV and mental health.

Through a new elective in HIV psychiatry, APA will provide 10 minority medical students with a unique opportunity to gain in-depth knowledge and experience in the mental health aspects of HIV and AIDS.

The new program is designed "to identify minority medical students and those who have primary interests in services related to HIV/AIDS and substance abuse and its relationship to the mental health or psychological well-being of ethnic minorities," according to Diane Pennessi, senior project manager in APA's Office of HIV Psychiatry.

APA will provide stipends to the chosen students with funds from the APA/SAMHSA Minority Fellowship Program. Participants will be paid for the cost of travel and receive a stipend to cover other expenses.

The core of the elective will be an intense, three-day training program in HIV psychiatry that will include topics such as the impact of HIV on the brain and mind; cultural issues in those at risk for or infected with HIV; the impact of antiretroviral medication on viral replication in the central nervous system; the emotional impact of HIV and its effect on the family, friends, and social network of infected individuals; and the pharmacological treatment of psychiatric symptoms and disorders in those infected with HIV.

The elective will take place in September. Students will be assigned to one of five training sites, each of which will have a mentor for the students. After a week at their assigned site, participants will travel to Washington, D.C., for the three-day training portion and then, after attending APA's fall component meetings, will return to their training site for an additional two weeks.

The sites that have signed up to date are medical schools at Harvard University, Columbia University, Emory University, and the University of Miami. APA is hoping to sign up one more site.

Applicants must be third- or fourth-year students in good standing at an accredited school of medicine or osteopathy in the United States. They must submit to APA a completed application form, a statement of interest no longer than one typewritten page, a letter from their school's dean indicating that they are in good academic standing, and a copy of their curriculum vitae.

Students chosen to participate will be granted APA membership if they do not already have it and will be able to attend APA's fall component meetings in Washington, D.C., where they will participate in meetings of the APA Committee on AIDS.

APA has indicated that the elective is a suitable rotation for students interested in psychiatry, internal medicine, pediatrics, or medical research careers.

The application deadline is March 30, with selections to be announced in late April.

Applications are posted online at <www.psych.org/aids>. Additional information can be obtained from Pennessi by phone at (703) 907-8668 or e-mail to dpennessi@psych.org. ■

Parity

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yet to act, though more than half its members have cosponsored this year's parity bill.

Michael Strazzella, deputy director for congressional relations in APA's Division of Government Relations, told *Psychiatric News* that although opposition from the insurance industry and business community exists, there have been positive signs for the prospects of passage.

"APA is encouraged by the recent commitments from Senate Republican leaders to take up the Paul Wellstone Mental Health Equitable Treatment Act early this year," Strazzella said. "It is imperative that all supporters of mental health parity continue their aggressive outreach to members of the House of Representatives." ■

Congress Votes for Modest MH Funding Boost

This fiscal year's budget for federal mental health and substance abuse research, services, and treatment programs was finally approved by Congress and signed into law by President Bush in January.

BY CHRISTINE LEHMANN

Congress appropriated modest increases for nearly every federal mental health and substance abuse program this fiscal year, a trend that is likely to continue in Fiscal 2005.

The budget for the National Institutes of Health increased by 3.7 percent, or $1 billion, for a total of $27.9 billion, according to the final omnibus appropriations bill (HR 2673) signed into law in January.

Congress agreed, however, to reduce nonmilitary and nondefense discretionary budgets by 0.5 percent this fiscal year, so the final NIH budget increase comes to 3.2 percent, according to Lizbet Boroughs, an associate director in APA's Division of Government Relations.

Although this is more than the president's requested increase of 2 percent for NIH, which the House of Representatives passed last year, it fell significantly short of the 10 percent boost advocated by the Ad Hoc Group on Medical Research Funding, Boroughs said.

APA participates in three coalitions that develop annual recommendations for federal health and mental health funding that are distributed to Congress. The Ad Hoc Group on Medical Research Funding focuses primarily on congressional appropriations for NIH, and the Mental Health Liaison Group (MHLG) focuses on congressional appropriations for the Center for Mental Health Services and the National Institute of Mental Health (NIMH), National Institute on Drug Abuse (NIDA), and National Institute on Alcohol Abuse and Alcoholism (NIAAA).

The third coalition in which APA participates is the Coalition for Public Health Funding, which recommends that programs and agencies within the Department of Health and Human Services (HHS) be adequately funded to meet the needs of the public, according to a coalition mission statement. APA's Division of Government Relations co-wrote both the ad hoc group and MHLG appropriations recommendation documents, which were distributed to Congress last year.

Boroughs explained that the Ad Hoc Group on Medical Research Funding and MHLG decided to advocate for a 10 percent increase for the NIH budget based on an estimated inflation rate of 3 percent to 4 percent for state-of-the-art medical research and a 6 percent to 7 percent desired growth rate in grants to accelerate the pace of research, said Boroughs.

NIH Director Elias Zerhouni, M.D., presented the Bush administration's Fiscal 2004 NIH budget request to the House Appropriations Subcommittee on Labor, HHS, and Education almost a year ago.

Zerhouni testified then that the president's budget request "will allow us to support our highest research priorities and continue the momentum we gained during the historic doubling of the NIH budget," according to his statement posted online. These priorities include obesity, diabetes, and implementing the provisions of the Best Pharmaceuticals for Children Act, which became law last year *(Psychiatric News*, September 19, 2003).

The legislation requires NIH to conduct studies in children of drugs no longer under patent and to provide technical assistance to drug companies that agree to conduct pediatric studies of their patented medications in exchange for an additional six months of patent protection.

Zerhouni said that the administration's proposed increase for Fiscal 2004 of 2 percent would enable NIH "to continue to support about 1 in 3 of the research grant applications we receive."

Boroughs told *Psychiatric News* that although the Senate approved a 3.2 percent increase for NIH, the Senate mandated that NIH use 2.2 percent of the increase to evaluate all its grant programs, leaving only 1 percent for biomedical research funding.

Mental Health, Addictions Institutes

NIMH, NIDA, and NIAAA received budget increases of between 2.92 percent and 2.99 percent this fiscal year. This represents a $41 million increase for NIMH over Fiscal 2003 and was the amount requested by the president. Congress increased the Fiscal 2004 budget for NIDA and NIAAA by $30 million and $13 million, respectively, which was a few million dollars less than what the president had requested.

After the 0.5 percent reduction for nonmilitary and nondefense spending mandated by Congress, the Fiscal 2004 budget totals for NIMH, NIDA, and NIAAA are $1.38 billion, $992 million, and $429 million, respectively, Boroughs noted.

CMHS Budget Battle

The Bush administration proposed that the Center for Mental Health Services (CMHS) budget be reduced by $22.9 million in Fiscal 2004.

The programs designated for reductions were the Community Mental Health Services Performance Partnership Block Grant, Protection and Advocacy for Individuals with Mental Illness, Jail Diversion Program Grants, Addressing the Needs of Children

please see ***MH Funding*** *on page 6*

Advocates Want Solitary Confinement Banned for Mentally Ill Inmates

"Think outside the box," urge advocates who want an end to solitary confinement for prison inmates who have mental illness.

BY KATE MULLIGAN

New York state advocates for mentally ill inmates are challenging the use of special housing units (SHUs), a form of solitary confinement in the state prison system.

They have the support of Assemblyman Jeffrion Aubry (D-Queens), who introduced a bill (A 8849) that would make it illegal to place persons with psychiatric disabilities in SHUs and would create alternative therapeutic housing areas for these individuals.

Robert Corliss, associate director for criminal justice for NAMI-New York State, said, "Assemblyman Aubry's bill has provided fresh momentum for galvanizing the different advocacy groups, some of which have worked on this issue for years," according to the February 5 *Albany Times Union*.

A press release from organizations supporting the proposed legislation points out that prisoners in SHUs "spend 23 to 24 hours a day in a barren concrete cell experiencing sensory deprivation, social isolation, and enforced idleness. . . ."

The release goes on to claim that the state's Department of Correctional Services houses nearly 5,000 prisoners in solitary confinement, which is 8 percent of the total inmate population, a percentage that is four times the national average.

The state's Department of Correctional Services claims that the 23-hour daily confinements have reduced assaults on inmates and prison guards.

At a press conference on January 27 in support of the legislation, Leah Gitter, a family member of a person with a psychiatric disability, told the group, "There is no way to express the misery and suffering produced by SHU confinement. I equate it with visiting a prisoner of war."

Between 1998 and 2002, more than half of the 48 suicides in the state prison system occurred while the inmate was in solitary confinement, according to the press release.

In October 2003, Human Rights Watch issued a 215-page document, "Ill-Equipped: U.S. Prisons and Offenders with Mental Illness," that cited data from APA's 2000 report "Psychiatric Services in Jails and Prisons." These data indicated that "perhaps as many as 1 in 5 prisoners was seriously mentally ill, with up to 5 percent actively psychotic at any given moment" (*Psychiatric News*, December 5, 2003).

In its report, Human Rights Watch recommended that prisons "exclude the seriously mentally ill from segregated confinement or 'supermax' prisons."

Sharon E. Carpinello, R.N., Ph.D., acting commissioner of the New York State Office of Mental Health, testified before state legislature budget committee on February 4 that the proposed budget for mental health includes $7 million in new funds that would help provide mental health services to inmates in SHUs and would also establish two behavioral-health units to serve as placement alternatives.

A news release from a coalition of organizations supporting the legislation is posted online at <www.nyaprs.org/enews/show_enews.php?id=1144>. ■

MH Funding

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and Adolescents with PTSD, and Mental Health Outreach and Treatment to the Elderly, Boroughs explained.

APA worked with key members of the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies to restore the CMHS funding.

Reps. Patrick Kennedy (D-R.I.), Rosa DeLauro (D-Conn.), and David Obey (D-Wis.) not only restored funding for the CMHS programs, but increased CMHS overall funding by $5 million over its Fiscal 2003 budget, Boroughs said.

APA praised the president for requesting that Congress increase the budget for the Comprehensive Community Mental Health Services for Children and Their Families Program by $8.2 million and the Projects for Assistance in Transition From Homelessness (PATH) by $6.9 million. Congress appropriated $3.9 million and $6.9 million, respectively, for these programs in the final appropriations bill.

The Fiscal 2004 budgets for the mental health institutes are posted online at <http://thomas.loc.gov/home/approp/app04.html>. Zerhouni's testimony is posted at <www.nih.gov/about/director/budgetrequest/FY2004budgetrequest.htm>. ■

Association News

Volunteers Needed

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

Va. Bill To Extend Insurance Coverage Elicits APA Testimony

The inability to offer health insurance to the domestic partners of employees in Virginia makes it difficult to compete for the best workers and worsens an already serious insurance crisis, APA tells a Virginia legislative committee.

BY KEN HAUSMAN

The Virginia House of Delegates took a step last month to change the law barring private companies from offering health insurance benefits to employees' domestic partners and other household members.

This is an important issue for APA, because the Association did not realize when it signed a lease to move its headquarters from Washington, D.C., to Virginia in December 2002 that the law in its new home state would not allow it to continue offering health care coverage for unmarried partners of its staff, as it has done for several years. APA learned of this situation when it informed its health insurance carrier about the new address.

In a fortuitously timed move, a bill was introduced in the current session of the state legislature to change the law.

The bill would give businesses the option of extending health insurance coverage to unmarried partners of same-sex or opposite-sex couples or to other members of an employee's household. The current law limits such coverage to employees' legal spouses and children.

Last month APA testified before the House of Delegates committee with jurisdiction over the bill to change a law that APA Medical Director James H. Scully Jr., M.D., characterized as "wrong-headed."

He also wrote in a letter to the editor of Washington, D.C.,'s gay-oriented newspaper, the *Washington Blade*, that APA had begun to work hard "to let other employers know that as long as the law stands, moving to Virginia is a mistake."

In a vote later on the day that APA and other business interests testified, the very-conservative Virginia House Commerce and Labor Committee narrowly voted to report a bill to the House floor that would allow the state's private employers to extend health benefits to domestic partners of employees.

> "Such benefits are inexpensive, but pay off handsomely in terms of productivity and morale."

A week later, on February 17, several days after Human Resources Director Linda Neely testified in favor of the bill on behalf of APA, the full House of Delegates passed

please see ***APA Testimony*** *on page 66*

Oregon Anti-Tax Vote Spells Trouble for Health Care

Oregon plans new cuts in health care services after voters reject tax increases.

BY KATE MULLIGAN

Oregon voters again rejected a tax increase that would have enabled the state to maintain access to health care services for the poor and near-poor through the Oregon Health Plan (OHP).

More than a year ago, in January 2003, state residents voted against an increase in the state's income tax that was designed to avoid cuts in health care services, education, public-safety measures, and other essential services.

As a result, the state eliminated access to outpatient mental health benefits and substance abuse treatment for approximately 100,000 residents and temporarily eliminated access to prescription drug coverage *(Psychiatric News*, April 4, 2003).

Later in 2003, Oregon's state legislature passed an $800 million tax increase intended to balance the state's 2003-05 budget. Measure 30, a voter referendum initiative, subjected the increase to a statewide vote.

Voters rejected the tax increase by 59 percent to 41 percent. In addition to a three-year income tax increase, the measure would have raised taxes on cigarettes, increased the minimum level of corporate taxes, and reduced the medical state tax deduction for seniors.

The legislature had spelled out $545 million in cuts that would take place if the tax increases were rejected. According to a statement on the Measure 30 ballot, about 52,000 persons will lose OHP coverage and other health care cuts will occur as a result of the defeat.

In the February 5 *Oregonian*, reporter David Austin described the cuts likely to occur in Multnomah County, which includes Portland.

He noted that as many as 25,000 people in the county will lose mental health services, including housing and financial help to pay for medication.

Gov. Ted Kulongoski (D) targeted health coverage for children and pregnant women, prescription drug coverage for seniors, and state crime labs as services he would try to preserve, despite the impending cuts.

He was quoted in the February 5 *Oregonian* as saying, "Oregon is not going to cease existing if this measure fails, but there will be drastic consequences to some of our most vulnerable citizens. Anybody that thinks this is all going to be absorbed in efficiencies and administrative costs is not telling you the truth." ■

Editorial Criticizes NIMH Agenda

BY CHRISTINE LEHMANN

In an editorial titled "Bird Brains" published in the January 20 *Wall Street Journal (WSJ)*, psychiatrist E. Fuller Torrey, M.D., president of the Treatment Advocacy Center, in Arlington, Va., argued that the National Institute of Mental Health (NIMH) funds too many studies of a dubious nature and too few studies of serious mental illnesses.

Torrey claimed that NIMH spends just 5.8 percent of its research budget on studies of serious mental disorders, though it is research into those disorders "that could lead to more effective treatment of schizophrenia, bipolar disorder, severe depression, and other serious mental afflictions."

Between 1972 and 2002, NIMH funded 92 research projects on how pigeons think and only one study on postpartum depression research, "a devastating mental illness that affects women like Andrea Yates, who killed her five children in Texas in 2001," Torrey stated.

NIMH Director Thomas Insel, M.D., responded in a letter to the editor published in the January 26 *WSJ* that NIMH in fact spends at least 60 percent of its research budget on serious mental illnesses and funded 33 studies on postpartum depression last year alone.

"Torrey fails to recognize how basic behavioral and neurobiological research has been, and will continue to be, critical for us to make progress against serious mental disorders," according to Insel's letter.

Insel concluded in his letter, "Torrey is right about one thing: these illnesses inflict an enormous cost, in emotional and economic terms, for patients and their families."

Torrey's editorial and Insel's letter to the editor are posted online at <www.wsj.com>; free access is limited to subscribers. ■

Moonlighting During Residency: Start Now!

BY ZAKARIA SIDDIQUI, M.D.

Moonlighting in medicine is defined as any professional activity done outside a resident's training program. Engaging in moonlighting has long been a tradition for residents to earn money beyond the modest salary provided by residency programs, yet residents are now hesitant about moonlighting and shy away from it for various reasons.

I began to moonlight only at the beginning of my fourth year of residency. I was a late starter not because I wasn't given permission earlier, but because I feared moonlighting might conflict with my regular clinical work and take time away from my family on weekends. I also had concerns about working unsupervised. However, the anticipation of being able to pay off my long-term loans faster persuaded me to give moonlighting a try.

The first time I worked over a weekend, I remember being enthusiastic and upbeat. Not knowing what to expect, I packed some books, including my favorites: *The Washington Manual of Medical Therapeutics* and Harrison's *Principles of Internal Medicine*. I had a colleague's phone number handy in case I needed a second opinion and advice. The clinical director of the hospital gave me a tour of the 30-bed inpatient state psychiatric facility and the keys to my office. My duties included doing morning rounds and evaluating new admissions.

I began morning rounds with no attending and medical students with me. For a moment, the task seemed daunting, and I felt the pressure of being alone. The presenting clinical problems were diverse, ranging from greenish eye discharge to constipation, persistently elevated temperature, and abdominal pain. In some cases I would have called for a medical consult if I were working as a resident, but this was a different story. While the nurses were cooperative and helpful, I had no one on whom to depend. I began to wonder why I had accepted this job at all.

Nonetheless, I persevered and managed to keep a cool, calm attitude. Recalling my cognitive-behavioral therapy techniques, I repeated to myself, "You have handled this in the past." As rounds progressed, my diagnostic skills and treatment decisions started flowing smoothly, and my confidence level began to rise.

Moonlighting can be divided into "internal moonlighting," which is moonlighting that occurs within the residency program and/or the sponsoring institution or the nonhospital sponsor's primary clinical sites, and "external moonlighting," which is moonlighting that occurs outside the residency program.

External moonlighting requires residents to obtain their own liability insurance. Internal moonlighting hours are counted toward the 80-hour weekly limit on duty hours as recommended in guidelines by the Accreditation Council on Graduate Medical Education. Moreover, residents usually cannot moonlight internally on their "day off."

There are several treatment settings suitable for moonlighting: emergency rooms, state psychiatric hospitals, and community mental health centers; another option is to conduct physicals for insurance agencies. Residents may be asked to do physical and mental evaluations if they work in long-term psychiatric facilities.

To begin moonlighting, residents should make a request in writing to the residency program director. The program director in most cases approves moonlighting requests for residents in good standing. Some programs, however, have restrictions depending on your training year and performance on PRITE.

Some tips:

- Obtain your state physician license and state controlled-substance registration number as a first step toward moonlighting.
- Be cautious and ask for a consult if you are unsure about how to handle medical problems. As a colleague of mine said, "It's nice to have the cash, but you don't want to start out your career with a lawsuit."
- Document clearly and be aware of seclusion and restraint rules.
- Always carry books for reference, even if you feel confident.
- Work over long weekends to make a substantial amount of cash at one time.
- Residents on a J-1 visa are prohibited from moonlighting, and violators may be at risk for deportation.
- Make sure moonlighting activities do not interfere with your residency training program's activities and requirements.

There are always some cons for every pro. By working extra hours, residents forfeit time to be with their families and engage in leisure activities, often endure long drives, and incur additional liability risks.

Still, I believe that independence associated with moonlighting is an invaluable way for residents to test the waters in the real world. It is also an educationally stimulating environment in which to hone one's general medical skills. It ultimately promotes professional growth, and I feel that all residency programs should encourage moonlighting. ■

Dr. Siddiqui is a fourth-year resident at Creighton-Nebraska Psychiatry Residency Program in Omaha.

Shuttered MH Center Blooms One Last Time

For all the patients with mental illness who never received flowers during their hospital stays, there is the Bloom Project, which for a short time transformed a psychiatric institution into a garden.

BY EVE BENDER

The Massachusetts Mental Health Center became a place of fantasy in its final days of existence—long hallways, nooks, and crannies carpeted with thousands of flowers.

Once dreary and sterile, the corridors came alive with color: yellow and orange tulips filled the passageways, for instance, as far as the eye could see. Grass lined the basement hallways that led to the facility's swimming pool, where a sea of blue violets replaced water.

The transformation was part of Project Bloom, an artistic project commemorating the Boston hospital's 91 years of service.

The hospital closed its doors for good on November 11, 2003, and Artistic Director Anna Schuleit and 85 volunteers scrambled during the following days to place approximately 28,000 potted flowers throughout the abandoned facility.

The exhibit opened to the public for four days beginning on November 14, and former hospital patients, staff, and others traveled from near and far to marvel at the surreal display.

Why flowers?

Schuleit, who created the exhibit, said psychiatric patients rarely receive flowers, unlike patients who are hospitalized with, for example, appendicitis or cancer.

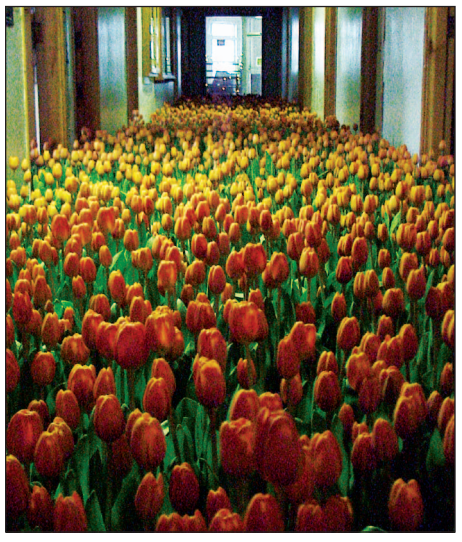
"I added up all the flowers that had never been given to patients at Massachusetts Mental Health over the years" and used the blooms as the basis of the exhibit, she told *Psychiatric News*. Schuleit relied on donations to purchase the flowers.

The flowers didn't go to waste. After the exhibit closed, Schuleit and her volunteers delivered them by truck to people in more than 40 facilities throughout Massachusetts and Rhode Island, including psychiatric facilities, clubhouses, and homeless shelters.

"That was a beautiful part of the project," she said.

A new Massachusetts Mental Health Center facility will eventually open on the site of the now-closed hospital. Until that time, staff and patients are at the the Lemuel Shattuck Hospital in nearby Jamaica Plain, Mass.

More information about the Bloom Project, including photos of the exhibit, is posted online at <www.bloomproject.org>. ■



Some Psychiatrists Keep It All in the Family

The saying "The apple doesn't fall far from the tree" couldn't be more true for psychiatrists who, inspired by their parents' love of the field, decided to follow the same path. See related story on page 14.

BY EVE BENDER

As with psychiatrists in any group practice, these colleagues share office space, consult with one another, and cover for one another during vacations.

But every now and then, a clinical discussion in the hallway turns into more of a lecture, which is likely to be met with a much-practiced rolling of the eyes.

One psychiatrist's professional accomplishments are described to outsiders with pride. And at the end of the day, farewells may be followed by a polite reminder about Sunday night dinner.

They are more than just colleagues; they are mothers and fathers sharing psychiatric practices with their adult children.

"She has the best of her mother and me," said Ray McCard, M.D., referring to his daughter, Sondralyn Fackler, M.D. The father-daughter pair opened a practice together in Macon, Ga., last March. "She has a natural talent for psychiatry," McCard said with undisguised pride.

Goodbye to Diplomacy

McCard, medical director of the Coliseum Psychiatric Center in Macon, started a solo practice in 1968. He was joined by a couple of additional psychiatrists in the following years, during which his daughter graduated from Georgetown University's School of Foreign Service.

"I thought she was going to be a diplomat," he said. But Fackler was headed in another direction.

"Dad," she told her father upon graduation, "I think I want to go to medical school."

So off she went to Emory University School of Medicine, where during her senior year she chose to work with her father as part of an elective. "I tried to make it a positive experience for her," McCard said. "She got a close look at what I did every day, and with my patients' permission, she sat in on med checks."

Fackler said that when she started medical school, she didn't know that she'd end up specializing in psychiatry.

Psychiatry Feels Like Home

"But on the first day of my psychiatry rotation," she said, "I felt like I was at home—that this was where I needed to be."

And she knows why. "Did my father influence my choice of career? Absolutely!" Fackler said. "Not by directing me into psychiatry, but by showing me what it's like to truly love what you do."

The two consult on certain cases, and Fackler said she benefits from her father's "wisdom and experience," during the consultations.

"She is a delight to work with," McCard said.

When Mark Sampson, M.D., became a staff psychiatrist at the Southcentral Counseling Center of the Anchorage Community Mental Health Services, David Sampson, M.D., decided to step down from his job as medical director there. It was a small sacrifice to make for his son.

The elder Sampson, who had worked there for 25 years, moved to a position as senior psychiatrist at the center, and in the process, his son inherited half of his dad's patient caseload.

Said Mark, "It was like a passing of the torch."

Although father and son meet at weekly medical team meetings, Mark admitted that he encounters his father's legacy more often than he does his father. For instance, a common refrain from his father's former patients goes something like this: "Your father didn't do it that way."

Said Mark, "Many patients will ask me how my father is doing and ask me to say hello to him," which is often followed by 'Did you know he treated me in the '70s?' "

After reflecting a moment, he added, "I think I represent something positive to them."

Mark said he thought practicing in the same mental health center as his father "would be really weird, but it turned out to be less weird than I thought it would be."

The elder Sampson agreed. "Neither of us knew quite what to expect at first," he said.

Father and son entered psychiatry at different times, for different reasons.

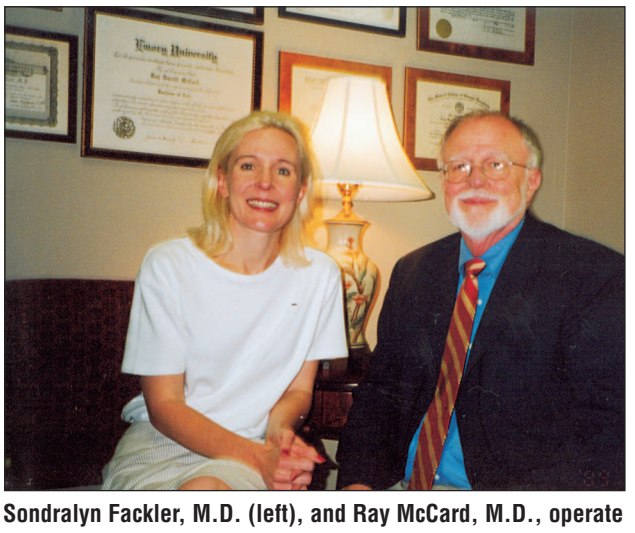
"I grew up being the mental health provider for my family," said David, "so there were a few things in my formative years that predisposed me to study how individuals relate to one another."

He said he didn't encourage his son to enter medical school but was happy that he did. "I'm especially happy that he chose medical school over the other career he was considering—brew master."

He minimizes his role in his son's career choice. "I would be hesitant to think I influenced my son's decision to enter psychiatry," he said.

Mark sees things differently. "I grew up listening to taped CME lectures on psy-

please see ***All in the Family*** *on page 17*



Sondralyn Fackler, M.D. (left), and Ray McCard, M.D., operate a practice together in Macon, Ga. "She is a delight to work with," McCard said of his daughter.

Like Father, Like Son. . . And Son, and Son

One after the other, Nakleh Zarzar's three sons followed in his footsteps by choosing a career in psychiatry and joining the family practice. Their father's passion for his work, the sons say, inspired them.

BY EVE BENDER

There is the occasional parent who maintains a psychiatric practice with his or her son or daughter, but far rarer is the psychiatric dynasty.

Nakleh Zarzar, M.D., is now retired, but during the late 1990s, he practiced psychiatry with sons Michael, David, and Nicholas in Raleigh, N.C.

"The practice with my sons has gone smoothly," he said.

The family consulted one another about clinical issues and said running the practice was a "democratic decision-making process."

After graduating from medical school in Beirut, Lebanon, Zarzar completed his psychiatry residency at the University of North Carolina School of Medicine in Chapel Hill in the late 1950s.

In the following years, Zarzar served as medical director of Dorothea Dix and John Umstead hospitals. From 1973 to 1977, he served as North Carolina's director of mental health.

Zarzar entered private practice in 1977, but it wasn't until 1990 that the eldest of his three sons, Michael, joined the practice. Nicholas joined a few years later, and the youngest, David, joined in 1997.

"My dad has always encouraged us in whatever we wanted to do," Michael told *Psychiatric News*. "He has always been there for us."

A psychiatric dynasty: Nakleh P. Zarzar, M.D., is photographed with his sons (from left) Michael Zarzar, M.D., David Zarzar, M.D., and Nicholas Zarzar, M.D.

Since their father's retirement, the three brothers maintain a private practice with two other psychiatrists and three mental health professionals.

Michael and his brothers admit to being influenced by a parent who loved his work.

When Michael was a college student, he volunteered at some of the hospitals where his father worked. "People would approach me and tell me how well my father took care of his patients and how he interacted with staff," Michael said.

"My dad has always encouraged us in whatever we wanted to do. He has always been there for us."

The three brothers spent part of their childhood in a house just 100 yards from John Umstead Hospital. "Patients with grounds privileges would sometimes come over to the house and talk to us," Michael recalled. "I enjoyed talking to them."

Nicholas said the experience of living so close to the hospital was a positive one. "I grew up with a respect for patients with serious mental illness," he said.

Said David, "Just watching Dad do something he loved influenced me."

There is much about the three brothers that is alike. For instance, their spouses all work in the health field: Michael's wife is a school psychologist, Nicholas' wife is a nurse, and David's is an occupational therapist.

The fact that the Zarzar brothers look alike can be confusing to patients, David admitted. "I grew a moustache so there would be more of a distinction between us," he said.

It probably doesn't help that the brothers sound alike, too. "When one of us is on call for the practice," David said, "sometimes one of our patients will mistake us for a different brother over the phone."

Despite hectic schedules, the Zarzar family finds time each month to spend together outside of work, according to the brothers, and mental health topics are verboten. Instead, they talk about "Carolina sports," "Dad's garden," and "family." ■

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Three States, Three Views Of Public MH Crisis

Community psychiatrists find new allies as they combat the "most serious fiscal crisis [for states] since World War II," but more cuts to public mental health services are looming.

BY KATE MULLIGAN

State budget cuts in Fiscal 2004 continue to accelerate, and that trend is likely to continue into the next fiscal year, according to a January report from the Kaiser Commission on Medicaid and the Uninsured (KCMU).

"State Responses to Budget Crisis in 2004: An Overview of 10 States" reported that states "found themselves with the need to make far more cuts in health care spending than in earlier years of the economic downturn."

Psychiatric News invited three members of the Board of Directors of the American Association of Community Psychiatrists (AACP) to describe the impact of budget cuts in their states and to discuss how additional damage to the health care system might be prevented.

AACP Secretary Jack Haggerty, M.D., is director of the Division of Social and Community Psychiatry at the University of North Carolina School of Medicine.

AACP's immediate past president, Charles Huffine, M.D., is assistant medical director for child and adolescent programs at the King County Mental Health, Chemical Abuse, and Dependency Services Division in Seattle and maintains a community-oriented, private practice specializing in adolescents with behavior disorders.

AACP's Area 1 representative, David Moltz, M.D., is a psychiatrist in Sweetser Community Integration Services in Brunswick, Maine, and for 11 years was the medical director of Shoreline Community Mental Health Services.

Different Causes, Similar Result

Each state has idiosyncratic factors that affected its response to the budget woes, which KCMU called the "most serious fiscal crises [for states] since World War II."

As in Oregon, which is about to face another round of budget cuts, the capability of Washington's state legislature to respond to budget shortfalls is subject to various limitations concerning powers to tax (see page 8).

Huffine said that Washington state's budget for mental health had been slashed three years in a row, in part because it's so difficult to "fix things," because of the state's "rigid and inadequate budgetary process."

> **"We need to put more real money where our mouth is in terms of advocacy for patients."**

North Carolina recently had suffered a "mammoth loss of revenue," because many of the state's core industries left the state, according to Haggerty. In addition, in 2001, the state began a major reorganization that involved moving from a traditional community mental health center (CMHC) service model to one in which regional administrative entities contract with service providers.

As part of this effort, the legislature closed state hospitals and established a trust fund of $40 million to fund community services for former patients and others. But North Carolina Gov. Mike Easley (D) was forced to use the fund to reduce the state's budget deficit during the crisis of Fiscal 2002, according to Haggerty, leaving only $12 million.

Bucking the trend toward decreasing coverage, Maine Gov. John Baldacci (D) embarked on an effort to establish the first statewide universal health insurance program in the country.

In June he signed a bill to establish Dirigo Health, a public-private health insurance program that aims to expand access to affordable insurance to the approximately 150,000 Maine residents who now lack it.

Moltz called the effort a "bright spot," but also described problems in the state.

"Mental health care [in the public sector] has become synonymous with Medicaid," he said. Medicaid budget cuts and patterns of reimbursement have resulted in demands for increased productivity, which, in turn, have decreased or eliminated time for such activities as interdisciplinary meetings and coordination with schools, which are necessary for good integrated care.

A dual system of care is developing in which those who have a financial need but are ineligible for Medicaid wait longer for treatment than those who are eligible.

Moltz spends "considerable time" helping patients become eligible for prescription-assistance programs offered by pharmaceutical companies to low-income people not eligible for Medicaid.

In North Carolina, the medically indigent and uninsured "are those being left out of the dance," according to Haggerty.

"We can't take care of people without insurance unless they belong to priority populations, including those with severe mental illness, specific categories of especially harmful substance abuse disorders, or significant developmental disorders," he said.

Care is also deteriorating because psychiatrists are leaving the CMHCs in anticipation of the shift to regional administra-

tion of services. Increased rates of hospitalization and use of emergency rooms are being reported.

Huffine warned, "The real issue isn't just about recent cuts. Mental health centers have been under severe financial constraints for the last five, and maybe 10, years."

He described a series of results. "Case loads rise. Training deteriorates. Young psychiatrists turn away from jobs in the public sector. Turnover is high."

The result is "erosion of services for the most-needy people."

Some Solutions Offered

Advocates have found strategies, however, to mitigate the damage of the budget cuts, some of which are inexpensive and easy to implement.

At a cost of just $10 a month, the Maine Psychiatric Association (MPA), for example, began a list serve in which 80 of the state's 300 psychiatrists participate.

"It is a very, very powerful tool to network for support for Medicaid changes," said Moltz.

MPA members worked with the state's chapter of the National Alliance for the Mentally Ill and the Maine Medical Association to "open up" the prior-authorization process for psychotropic medications funded by Medicaid and to encourage use of a monitoring system that identifies aberrant prescribing and provides education to psychiatrists.

MPA also established a program in which psychiatrists volunteer to provide telephone consultation to primary care physicians in areas of the state where there is limited access to mental health services.

The Washington State Psychiatric Association teamed up with other mental health advocacy associations and organizations representing county governments and the criminal justice system to create the Partners in Crisis program.

"When Medicaid cuts are threatened, we are able to mobilize sheriffs and other law-enforcement people who can speak persuasively about the likely impact on jails and budgets for the criminal justice system," said Huffine.

He also said that at the urging of mental health advocates, the legislature was "paying attention" to wraparound models that integrate funding sources to provide coordinated services.

Huffine thinks APA could be more helpful in addressing issues such as Medicaid waivers—in coordination with district branches—that are determined by the federal Centers for Medicare and Medicaid Services.

Haggerty invited APA to work with the AACP to find ways to empower psychiatrists and district branches to work more effectively to thwart budget cuts in public mental health. "We can help others figure out strategies, because we're already doing it," he said.

Public-sector psychiatry in North Carolina benefits from the strong interest of the North Carolina Psychiatric Society and its executive director, Robin Huffman, who chairs the statewide coalition that lobbies on mental health issues.

Haggerty emphasized the importance of maintaining coalitions and urged caution about advocacy for issues that could divide them.

At the time of this interview, Moltz was scheduled to testify for MPA against a bill (LD 1713) that would permit psychologist-prescribing privileges in Maine. "I've never seen such a mobilization of resources on the part of APA," he said.

"If we put the same amount of money, energy, and resources into fighting budget cuts to mental health services as we do to defeating psychologist prescribing, we would be in a far better place. We need to put more real money where our mouth is in terms of advocacy for patients."

The report, "State Responses to Budget Crisis in 2004: An Overview of Ten States," is posted online at <www.kff.org/medicaid/7002.cfm>. ■

All in the Family

continued from page 13

chiatry during long car trips," he said. "I'd also hear my father talking about his work," which he said ignited an interest in treating patients with mental illness. His experiences during clinical rotations as a medical student cemented his desire.

"It would be impossible to say my father didn't have a role in my decision," he said.

David, who is president of the Alaska District Branch, does admit to influencing his son's decision to get involved in APA governance—his son is secretary of the district branch.

For Bruce Wright, M.D., entering a group practice with his father, Alan Wright, M.D., was the right decision. "It was a great thing to enter the business and work with someone I could trust," he said.

Bruce helped his father conduct library research for his practice when he was a psychiatry resident at the University of Pittsburgh School of Medicine's Western Psychiatric Institute and Clinic.

When he graduated in 1992, he worked at a nearby state hospital for a few years and then entered his father's group practice. "Working with a family member made me feel better about the decision," he said.

The junior Wright divides his time between his practice with his father and his role as chair of psychiatry at West Penn Hospital in Pittsburgh.

Although the practice with his father has gone well, Bruce said, it may have unintentionally created a bit of family strife.

"Sometimes my sister gets a bit envious," he said. "She is not in the business and sometimes may feel a little left out."

Father and son said the practice runs smoothly. "We've always gotten along and relate well to one another as professionals," Bruce said.

Alan agreed. His son, who was trained more recently, "brought some new and different ideas" to the practice. "We complement one another well," he said. ■

WYETH EFFEXOR
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Use of S&R: Patient Safety, Risk Management Considerations

This article is one in a series on what psychiatrists can do to ensure they are practicing in a safety-conscious manner. Use of seclusion and restraint is potentially dangerous not only to patients but to staff as well.

BY DONNA VANDERPOOL, J.D., M.B.A.

I'd like to begin this month's patient safety article with a correction: The summary of the last article in the series, "A Few Simple Steps Can Avert Medical Errors," published in the February 6 issue, stated that "[m]ost malpractice lawsuits against psychiatrists stem from medication errors." The summary should have quoted Charles Cash, J.D., as saying, "Most lawsuits against psychiatrists include allegations involving medications, and many of those lawsuits involve preventable medication events."

Medical errors in psychiatry came into the national spotlight years ago due to a series of articles in the *Hartford Courant* investigating patient deaths during seclusion and restraint. Patient safety during this intervention is a serious concern. In fact, seclusion and restraint has been identified by APA's Task Force on Patient Safety as one of the three priority areas to reduce preventable adverse events in psychiatric practice. The risk management process can be used to manage the risks of harm from seclusion and restraint, not only to the patient, but also to staff.

Step 1: Identify Current and Potential Risks

Risks to the patient associated with seclusion and restraint include emotional and/or psychological harm, physical injury, and even death. The psychiatrist and facility also have risks associated with such adverse events, which could include any combination of the following: litigation against the facility and psychiatrist, licensing board complaints against the psychiatrist, and investigation of the facility by the government and/or accrediting organization. And, although the focus of this article is on patient safety, it should be noted that injuries related to restraint and seclusion of patients are among the most frequent workplace injuries for mental health care workers.

Step 2. Evaluate Risks (Frequency and Severity)

There have been concentrated efforts, in addition to governmental mandates, to decrease the use of seclusion and restraint, and thus the frequency of potential risks. The severity of injury can range from less severe to very high, as evidenced by reported cases of patient deaths.

As mentioned above, the risk to employees is significant; in fact, one of the most costly impacts of use of seclusion and restraint is the workers' compensation costs related to employee injury. Other adverse impacts on employees could include decreased worker productivity, decreased employee satisfaction and morale, and increased employee turnover. These negative impacts on employees could hamper efforts to create a culture of safety.

Step 3: Choose a Risk Management Strategy

To manage the risks associated with the use of seclusion and restraint, individual psychiatrists need to understand their professional liability exposure and the important role their involvement and leadership can play in improving patient safety and decreasing their liability.

While individual psychiatrists, either in the role of attending physician or medical director (responsible for seclusion and restraint policies and procedures), may not often be involved in an intervention utilizing seclusion and restraint, they are likely to be named in any lawsuit resulting from such intervention. Therefore, in terms of patient safety and professional liability, the only appropriate risk management strategy for a psychiatrist is to ensure patients' clinical needs are appropriately met. In fact, the APA Task Force on Patient Safety recommends that individual psychiatrists "support programmatic efforts to minimize the use of restraints and seclusion and to ensure that, when such interventions are necessary based on clinical judgment, they are administered safely by trained personnel," and they should "seek information about best practices."

The psychiatrist needs to review the facility's seclusion and restraint policies and procedures; minimizing the risks associated with the use of seclusion and restraint revolves around the development, use, evaluation, and improvement of a system. The use of a systems approach for seclusion and restraint is, in effect, mandated by regulations from the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, and JCAHO accreditation standards.

When evaluating a facility's system, keep in mind that the optimal system consists of policies and procedures that are understood by all staff, implemented appropriately, and re-assessed with the goal of utilizing seclusion and restraint as infrequently as possible to ensure the safety of the patient and the staff. In developing, reviewing, and improving a facility's system, the psychiatrist should remember the following:

Donna Vanderpool, J.D., M.B.A., is the assistant vice president of risk management at Professional Risk Management Services Inc., manager of the Psychiatrists' Program, the APA-endorsed Psychiatrists' Professional Liability Insurance Program.

- Seclusion and restraint should only be used as a last-resort treatment.
- State and federal law must be complied with, and accreditation standards must be met.
- Only accepted techniques are to be used—providers must be knowledgeable about current intervention techniques and professional standards and guidelines, including those addressing special populations such as geriatric, child/adolescent, and hearing-impaired patients.
- Staff must receive orientation, training, and reviews regarding seclusion and restraint practices.
- Adequate education about seclusion and restraint must be provided to patients, families, and significant others.
- Each episode of seclusion or restraint of a patient should be reviewed with staff.

Step 4: Implement the Strategy

Everyone involved in patient care needs to be committed to making the system work, and the importance of the psychiatrist's support of a clinical culture of safety cannot be understated. A facility can have the best seclusion and restraint policies and procedures on paper, but if they are not followed, patient care may suffer. Psychiatrists need to be vigilant and advocate for continued reduction in the use of seclusion and restraint. Meeting the patients' clinical needs will reduce the psychiatrist's liability exposure, whether the involvement is as an attending psychiatrist or a psychiatrist in an administrative role, such as medical director.

Step 5: Evaluate the Strategy

This final step in the risk management process is a continuous one. Each use of seclusion and restraint must be assessed, and psychiatrists should continue to advocate for additional therapeutic interventions to limit further the use of seclusion and restraint. Successful efforts should continue to be shared with colleagues.

Using the risk management process to approach the issue of seclusion and restraint supports the quality of care provided to patients, which corresponds to increased patient safety as well as patient satisfaction. ■

Guidelines and Best-Practices Resources for S&R Use

- **American Psychiatric Association:** Resource Guide on Seclusion
- **American Academy of Child and Adolescent Psychiatry:** Practice Parameter for the Prevention and Management of Aggressive Behavior in Child and Adolescent Psychiatric Institutions, With Special Reference to Seclusion and Restraint, 2002, www.aacap.org
- **National Association of Psychiatric Health Systems and American Hospital Association:** Guiding Principles on Restraint and Seclusion for Behavioral Health Services, 1999, www.naphs.org
- **American Geriatrics Society:** Position Statement: Restraint Use, 2002, www.americangeriatrics.org
- **National Association of State Mental Health Program Directors' Medical Directors Council:** Reducing the Use of Restraint and Seclusion, 2002, www.nasmhpd.org
- **American Psychiatric Association, American Psychiatric Nurses Association, and National Association of Psychiatric Health Systems:** Learning From Each Other—Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health, 2003, www.psych.org/research/training_fund/clin_res/LearningfromEachOther.pdf
- **Massachusetts Coalition for the Prevention of Medical Errors:** Best Practice Recommendations to Improve Patient Safety Related to Restraint and Seclusion Use, 2003, www.macoalition.org
- **Occupational Safety and Health Administration:** Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers (OSHA Publication No. 3148), 2003, www.osha.gov

Online Evaluation Gets New CPT Code

The American Medical Association announced in December that it has created a temporary Current Procedural Terminology (CPT) code (0074T) for online medical evaluations of patients by physicians and health care professionals.

The new code falls under Category III CPT temporary codes, which are used for emerging technology, services, and procedures, according to AMA spokesperson Katherine Hatwell.

Public payers such as Medicare will officially implement the code on July 1; however, private payers may reimburse physicians for online medical consultations before then, said Hatwell.

"The six-month lag time is needed to allow payers to add the new code to their systems," said Hatwell. "The AMA introduced the new code to make it easier to report and track online consultations; however, payment for these services remains the prerogative of the payer."

Services that may be eligible for reimbursement under the new CPT code are the physician's timely online response to an established patient's request, related phone calls, prescriptions, and laboratory orders. The online response must be stored or printed out as a hard copy. Ineligible services are patient contacts unrelated to the online communication, according to the AMA.

The new code and other early-release Category III CPT codes are posted on the AMA Web site at <www.ama-assn.org/ama/pub/article/3885-4897.html>. ■

New Rules Limit Eligibility For J-1 Visa Waivers

Guidelines issued by the Department of Health and Human Services place limits on the number of physicians who will be able to apply for J-1 visa waivers to work in underserved areas of the United States.

BY EVE BENDER

Only physicians working in the neediest areas of the United States will qualify for waivers of foreign residency from the Department of Health and Human Services (HHS) under new application requirements issued in December 2003.

Under the new guidelines, which became effective in January, HHS will process J-1 visa-waiver applications only for physicians working in regions the government designates as Health Professional Shortage Areas and who score at least 14 on a 25-point scale that assesses several criteria about the area in which the physician would be practicing.

When HHS began accepting these waiver applications in June 2003, there were no score requirements. HHS suspended the program in October 2003 so it could review its policies and then reopened the program in January under the new guidelines.

Personnel from the Shortage Designations Branch within HHS's Health Resources and Services Administration assign the scores based on a number of variables including the population-to-health-care-provider ratio, the extent of poverty in the area, and the average travel distance to reach a health care facility in the area.

In mental health shortage areas, the proportion of children and elderly people and the rates of alcohol and substance abuse are also taken into consideration.

Furthermore, HHS will accept waiver applications only from health care professionals working in certain health care centers in a particular region. Qualifying facilities are public health centers as defined by the Public Health Service Act, a rural health clinic as defined by the Social Security Act, and a Native American/Alaskan Native tribal medical facility as defined by the Indian Self-Determination and Education Assistance Act.

The U.S. Immigration and Naturalization Service requires foreign-born physicians who receive residency training in the United States to return to their countries of origin for at least two years following training before they can renew their visas. In inner cities or rural areas, however, certain agencies can request a waiver that would allow these physicians to stay in the country following residency training if they agree to practice in the underserved areas for at least three years.

According to Joyce Jones, an official with the HHS Exchange Visitor Program, the new guidelines will "target the populations and communities in greatest need."

Jones said she doesn't expect that the new guidelines will severely restrict the number of physicians applying for waivers. She noted, for example, that HHS had processed only 37 waiver applications since it began acting as an "interested government agency."

But psychiatrist Godehard Oepen, M.D., chair of APA's Committee on International Medical Graduates, disagreed.

He noted that before December 2003, there was no score requirement. As a result, the new rules "narrow down the options for international medical graduates [IMGs], who are known to provide care where American graduates don't want to go—to rural settings, professional-shortage areas, and state hospitals," he said.

Oepen also said that IMGs "fulfill another essential role in providing care for patients who are of racial and ethnic minorities and enrich our profession with a diversity of cultural, ethical/spiritual, and linguistic perspectives. . . .They are one of the main sources of the richness and superiority of American medicine."

More information on U.S. Health Professional Shortage Areas, including criteria used to determine such areas and a searchable database of Health Professional Shortage Areas, is posted online at <bhpr.hrsa.gov/shortage/>. ■

Nominations Sought

Nominations are now being accepted for the 2005 APA/NIMH Vestermark Psychiatry Educator Award. The award is named for the late Seymour Vestermark, M.D., the first director of the NIMH psychiatry education branch.

The award consists of a plaque and a $1,000 cash award. The winner will be invited to present a lecture on a topic related to psychiatric education at an APA meeting.

Eugene V. Beresin, M.D., will receive the award and present the lecture at APA's 2004 annual meeting in New York City.

The Vestermark Award Committee will accept nominations for the 2005 award postmarked on or before June 30. Letters should focus on the nominee's contributions to psychiatric education and include a current curriculum vitae. Nominees will be evaluated on the nature, scope, and quality of their educational contributions, activities, and leadership. The number of supporting letters is not considered in selection.

Nominations should be sent to Vestermark Award Committee, c/o Mark Anderson, Division of Education, APA, Suite #1825, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. ■

JANSSEN RISPERDAL

P4C

Live From New York, And You Are There!

Are you a big fan of David Letterman? The latest "Saturday Night Live" ensemble? If you plan now, you may be able to skip school and watch TV while you are in New York for APA's 2004 annual meeting.

BY EVE BENDER

Let's face it—it won't earn anyone CME credit, but being an audience member on the set of "Good Morning America" will be a different kind of education—a chance to get a behind-the-scenes glimpse of TV in the making.

At any given moment in New York, there is probably a TV show being taped, and live audiences are an essential part of the experience for show hosts, guests, and TV viewers alike.

From morning news shows to late-night comedy shows, there is something for everyone. While some may prefer the banter between Regis and Kelly, others are partial to David Letterman and his legendary top-10 lists.

For those who live outside of New York, there is good news—out of towners typically have an easier time getting tickets to live TV tapings than do New Yorkers, and tickets are free.

The best way to ensure a spot in any TV audience is to mail a postcard requesting tickets six months to a year ahead of the visit, but many people can't plan that far ahead.

Fortunately, for those who come to New York without any tickets, there is the "standby" line. Studios usually hand out a limited number of extra tickets on the day of each taping with the expectation that some ticket holders will not show.

Hearty souls (or insomniacs) have the best chance of getting standby tickets for morning shows; the trick is to line up in front of the TV studio of your choice at the crack of dawn.

Here are some of the shows offering free tickets to live tapings in Manhattan:

• **"Good Morning America":** Visitors can join hosts Diane Sawyer, Charlie Gibson, and Tony Perkins in their Times Square studio at the corner of Broadway and 44th Street by reserving tickets ahead of time at (212) 580-5175 or online at <abcnews.go.com/sections/GMA/GoodMorningAmerica>. A limited number of tickets are distributed early on the morning of the broadcast, which occurs each weekday from 7 a.m. to 9 a.m.

• **"Late Night With David Letterman":** The word is that these are the hottest TV tickets in town. Ticket requests can be sent via postcard from six to nine months in advance to Late Show tickets, Ed Sullivan Theater, 1697 Broadway, New York, N.Y. 10019. Tickets can also be reserved online at <www.cbs.com/latenight/lateshow>. Although no tickets are distributed on site, those who wish to be in the studio audience can call (212) 247-6497 by 11 a.m. to reserve them. Tapings are held Monday through Thursday at 5:30 p.m. with a second taping on Thursdays at 8 p.m., but it's a good idea to get there at least an hour in advance. Members of the studio audience must be 18 or older.

• **"Live! With Regis and Kelly":** Audiences can hear co-hosts Regis Philbin and Kelly Ripa chatting up their famous guests at the ABC studios at 7 Lincoln Square on the Upper West Side. While advance tickets must be reserved at least a year ahead of time, standby tickets are sometimes available. It's a good idea to arrive at the studio no later than 7 a.m. and request a standby number; tickets are handed out on a first-come, first-served basis. Audience members must be aged 10 or older, and anyone under age 18 must be accompanied by a parent.

• **"Saturday Night Live":** SNL tickets are in such demand that the lottery system for advance tickets is usually suspended. However, those who want to try and reserve tickets can call (212) 664-3056 as far in advance of their visit as possible to determine the current ticket-request procedure. People may have more luck stopping by the studio in person on the morning of the taping to get standby tickets, which are distributed at 7 a.m. outside 30 Rockefeller Plaza, on the side of the building that faces 49th Street. Only one ticket per customer is allowed. Taping begins Saturday nights at 11:30 p.m.; there is also a dress rehearsal at 8 p.m. on Saturday nights. No one under 16 is admitted.

• **"Today Show":** Katie Couric, Matt Lauer, and Al Roker are extremely popular with the city's tourists. To be a part of the show, visitors are encouraged to show up outside Today's glass-encased studio at Rockefeller Center, on the corner of 49th Street and Rockefeller Plaza. No tickets are needed, but signs—the more creative the better—are likely to increase one's chances of an on-air chat during the weather or introductory segments. The show runs from 7 a.m. to 10 a.m. ■

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

DBs Report Members Dropping Managed Care

Although psychiatrists may be breaking free of the burdensome preauthorizations often required by managed care, it seems that's not enough to keep psychiatrists on managed care panels.

"We kept hearing that psychiatrists were leaving managed care panels," said Lawrence B. Lurie, M.D., chair of the APA Committee on Managed Care, "so we decided to ask the district branches and state associations [DBs/SAs] directly about the state of managed care in their areas."

In August 2003 the committee sent a letter with nine questions about managed care to each DB/SA. Their responses showed that access to services (especially for inpatient admissions), administrative hassles, and slow claims payments—not to mention low rates of reimbursement—are still major concerns for psychiatrists and their patients. "As a result," said Lurie, "psychiatrists are dropping out of managed care."

The DBs made the following general points:

- As expected, some companies are better to work with than others. However, a company that was rated highly in one DB rated poorly in another. Conclusion: one can't make generalizations about managed care companies.
- Nationwide, many companies are dropping preauthorization requirements or reducing the amount of paperwork.
- APA members are finding pharmacy benefit managers (PBMs) increasingly intrusive. As one member from Massachusetts put it, "We are spending less time on getting psychiatric visits approved, but more time on getting meds approved."
- Parity laws, while celebrated, have had no effect on the day-to-day practices of psychiatrists.
- Mental health benefits vary widely from employer to employer.

Specific DB Responses

Below are some of the specific responses from the DBs.

Georgia Psychiatric Physicians Association: All companies have the occasional "system meltdown," which often seems to account for slow reimbursements; one company is hard to reach on the phone. Many MCOs have determined that preauthorization for CPT code 90805 and 90862 is interchangeable. Most psychiatrists who primarily do traditional psychotherapy have opted out of the insurance plans.

South Eastern Massachusetts Psychiatric Society: Reimbursement rates have been generally "flat." PBMs are a problem, especially with Medicaid. There are no noteworthy differences among the MBHOs in terms of quality—whether carved out or carved in. About one-third of members have opted out of all managed care plans and do not accept new patients covered by them.

Michigan Psychiatric Society: Some companies are negotiating reimbursement rates, and some have improved their relations with psychiatrists. Most PBM issues relate to the Medicaid formulary.

Minnesota Psychiatric Society: Managed care problems have "leveled off" with more integration of services and more dialogue. Patient access, however, is a problem, which all parties are addressing. Psychiatrists are increasingly opting out of managed care networks, especially those who practice psychotherapy. PBMs are requiring arbitrary preauthorizations. Administrative demands continue to rise, and late payments are common. Most psychiatrists do medication evaluations, for example, CPT code 90862, because it is too difficult to get preauthorization for CPT code 90807.

West Hudson Psychiatric Society in New York: The number of psychiatrists accepting patients covered by managed care is rapidly dwindling. There is a significant problem with access to services and "phantom" provider lists. PBMs are increasing the amount of time spent on time psychiatrists spend on prescribing medications.

Oregon Psychiatric Association: There are fewer requirements for preauthorizations.

Texas Society of Psychiatric Physicians: Many claims are not paid on time. No company is accepting E&M codes. PBMs are taking more and more of psychiatrists' time, and some are altering the physician's choices about first-line treatment. Most members are taking new patients covered by managed care. There are differences in the MBHOs, that is, some have physician-friendly Web sites, while others are hard to contact. Only one MCO makes follow-up calls about quality issues. In general, the carveins have better integration of care; the carveouts are less efficient and more costly. Employers offer widely different mental health coverage: oil companies, railroads, high tech firms, and one major airline are at the high end of coverage.

Psychiatric Society of Virginia: Managed care has increased its penetration in some areas, but several members believe there are fewer hassles, especially for medication management. Still, integrated treatment is difficult to obtain. Medicaid's paperwork and low reimbursement rates are particularly problematic. Inpatient lengths of stay are troublesome, as well as authorization procedures for continuing services. Reimbursement rates are extremely low, which local MCOs have promised to remedy. Payment of claims is slow. One company dropped preauthorization for CPT codes 90862 and 90805, which are reimbursed at the same rate. One company is allowing the use of E&M codes, but has a "fixed reimbursement rate" at the CPT code 99241 level regardless of the level of service provided. PBMs are becoming an increasing problem: newer medications require higher copays, there's a tendency to deny payment on "administrative" (as opposed to clinical) grounds so there is no appeal option, and reimbursement for doses above amounts specified in the *PDR* are difficult to obtain. With the exception of psychiatrists in areas such as Northern Virginia, most members are taking new patients covered by managed care. Administrative work is increasing. The state managed Medicaid program was deemed "virtually unworkable." Employers who value their employees more as individuals rather than as interchangeable "widgets" tend to provide better coverage, especially for companies that make a large investment in education or training of employees.

West Virginia Psychiatric Association: Reimbursement rates are going down, and payment of claims varies. Some individuals are contemplating not accepting Medicaid-insured patients because of the low reimbursement rates and increased management of the plan. PBMs have increased the time psychiatrists spend on prescribing and, in many cases, the formulary has altered choices about first-line treatment. Most members are taking new patients covered by managed care, but some physicians will not accept patients covered by certain plans. Employers are providing widely different coverage, although none of the coverage would be rated "high quality."

> **"We were surprised at how many of the problems are pervasive—poor access to services, hassles, and low and slow-to-arrive reimbursements."**

The Next Step

"We suspected that there were wide variations in the practices of MBHOs throughout the country," Lurie said, "and there are; but we were surprised at how many of the problems are pervasive, for example, poor access to services, hassles, and low and slow-to-arrive reimbursements."

Managed care has come a long way since the Committee on Managed Care surveyed the DBs in 1994. At that time psychiatrists were concerned about getting *onto* managed care panels, being terminated from managed care networks, and passing any willing physician legislation. The committee established the Managed Care Help Line to monitor these problems and assist members.

"We encourage the DBs and SAs to take advantage of using the Help Line," said Lurie, "so that the committee can correct problems reported." For example, Lurie noted the committee's work on halting Oxford Health Plans' efforts to audit member records and collect past reimbursements *(Psychiatric News*, January 2). The committee is routinely in contact with medical directors in MCOs and MBHOs and encourages APA to seek appropriate legislation when necessary.

Lurie emphasized that individual psychiatrists may be able to negotiate higher reimbursement rates. "Some companies are more responsive than others," he said, "but MCOs rarely initiate higher reimbursement rates themselves."

APA members and DBs/SAs may reach the Managed Care Help Line at (800) 343-4671. The Committee on Managed Care welcomes additional reports from the DBs/SAs. They may be e-mailed to managedcarecaucus@mail.psych.org.

The Committee on Managed Care's August 2003 letter to DBs/SAs is posted online at <www.psych.org/members/newsletters/ppmc/index.cfm> in "Members Corner."

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

Managed Care Complaints

The Managed Care Help Line, which is staffed by the Office of Healthcare Systems and Financing, handled more than 1,135 calls from members in 2003, 171 of which represented intensive case work to resolve managed care issues. Of those, nearly 88 percent of the complaints were resolved.

According to Karen Sanders, manager of the Help Line, APA received about 60 percent fewer managed care complaints in 2003 than in 2002. Although there was a slight decline in Help Line activity overall in 2003 compared with previous years (1,677 calls in 2002, and 1,257 calls in 2001), Sanders hopes psychiatrists will continue to pick up the phone and let APA know when they encounter problems with insurers or pharmacy benefit managers. "We can't help if we don't know about the problem," she said.

Breakdown of Help Line Complaints by MCO/Insurer, 2003

	Total complaints	Resolved	Unresolved
Aetna	5	5	0
APS	3	0	3
Cigna	8	0	8
Magellan	52	52	0
MHN	2	2	0
Oxford	21	13	8
PacifiCare	3	3	0
Secure Care	2	2	0
Tricare	3	3	0
UBH & UHC	9	9	0
ValueOptions	10	10	0
Various Blue Crosses	27	25	2
Various State Medicaid	25	25	0
Veterans Affairs	1	1	0
All	**171**	**150**	**21**

Call the Managed Care Help Line at (800) 343-4671.

High Court Poised to Rule On HMO Lawsuit Exemption

In 1997 Texas passed the Texas Healthcare Liability Act, the first state law guaranteeing patients the right to sue a health plan for negligent medical-necessity decisions. But insurers claim that they are exempt from such laws.

BY MARK MORAN

APA has signed onto a friend-of-the-court brief with the American Medical Association (AMA) and the Texas Medical Association (TMA) in support of two combined cases before the U.S. Supreme Court involving patients' rights to hold HMOs liable for decisions about their medical care.

The cases involve Aetna Health Inc. and Cigna Healthcare of Texas. One tests whether a health plan can mandate use of a certain drug, despite side effects and against the physician's best judgment.

The other tests a health plan's determination of medical necessity for a hospital stay, again against the physician's best judgment.

Both patients sued under the Texas Health Care Liability Act, which grants patients the right to sue a health plan for negligent medical-necessity decisions. The U.S. Fifth Circuit Court of Appeals remanded the cases back to state court, and the health plans are appealing that decision to the U.S. Supreme Court. Aetna and Cigna want the cases heard in federal court, where mandatory awards are more limited than in state courts, according to the TMA.

Neither of the plaintiffs were psychiatric patients, but Renée Binder, M.D, chair of APA's Committee on Judicial Action, said APA has a keen interest in efforts to hold HMOs accountable for medical decisions.

HMOs Can't Duck Responsibility

"It is a very important case," Binder told *Psychiatric News*. "We need to hold managed care companies accountable for their decisions. They are not just making financial decisions; they are making decisions that impact people's ability to receive health care. Whoever has the authority to make these decisions has to be responsible for those decisions."

She is a professor of psychiatry at the University of California, San Francisco School of Medicine, and director of its Psychiatry and the Law Program.

Binder and Richard Taranto, legal counsel to the Committee on Judicial Action, explained that the committee reviews cases that are scheduled to be heard by the Supreme Court—primarily those that could impact psychiatrists and their patients—and determines whether to offer an opinion on the basis of the relevance of the case to psychiatry and medicine.

In the Texas cases, the friend-of-the court brief in support of the patients was written by the AMA.

"The legal issues apply generally to patients who are denied care by HMOs," Taranto told *Psychiatric News*. "It doesn't matter that the patients don't happen to be psychiatric patients. The AMA and APA have a common interest in wanting HMOs to be essentially liable for malpractice in the same way that a physician who makes a bad treatment decision would be."

ERISA Limits at Issue

At the heart of the two Texas cases is the interpretation of federal Employee Retirement Income Security Act (ERISA) regulations as they apply to health plans. ERISA, passed in 1974, was originally designed to protect employee pension plans from fraud and mismanagement, and it includes rules exempting companies from state regulations when those companies operate in multiple states.

In 1997 Texas passed the Texas Health Care Liability Act, the first-in-the-nation law guaranteeing patients the right to sue a health plan for negligent medical-necessity decisions. But health plans have claimed exemption, under ERISA, from such state laws.

"The issue in these cases is whether insurers can hide behind federal ERISA rules in an attempt to deny timely, adequate patient care, and without accountability as mandated by the state of Texas," said Rocky Wilcox, J.D., TMA general counsel.

"Logic at the time ERISA passed was that it adds costs when multistate health plans have to meet the regulatory requirements of all the states in which they operate," Wilcox said. "A single federal law made sense. But in this instance, we contend ERISA has no bearing. Once an individual has been accepted into a health plan, he or she then becomes a patient.

"ERISA continues to regulate the individual's status as a 'participant' in the employee benefit plan, but ERISA does not preempt state law if the health plan's actions equate to negligent diagnosis or treatment," Wilcox maintained. ■

Association News

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Prison Program Fosters Bonding Between Women, Newborns

A multiagency program is helping to break intergenerational cycles of abuse and trauma by helping incarcerated mothers in Maryland overcome mental health problems and bond with their newborn babies.

BY EVE BENDER

When Joan Gillece, Ph.D., toured the maternity unit of the Baltimore City Detention Center a few years ago, she was unprepared for what she saw: dismal, stark surroundings and women despairing in the knowledge that they were about to lose their babies. One woman who had delivered her baby just 24 hours earlier was clutching a picture of her newborn infant under the covers.

"I found out these women were shackled to stirrups while they delivered and sent back to detention from the hospital the following day with a Polaroid picture of their newborn infants," she told *Psychiatric News*. "That was it."

The infants often went to foster homes. Sometimes they went to live with one of the inmate's family members.

Gillece, who is director of Special Populations for the Maryland Mental Hygiene Administration, said the mothers, many of whom had been repeatedly traumatized throughout their lives, now had the additional trauma of having their babies taken away from them.

Joan Gillece, Ph.D., and Andrea Karfgin, Ph.D., are the movers behind the Tamar's Children program.

The new mothers weren't the only ones who suffered. "The babies, due to disruption of their earliest attachments, are at risk for mental health problems down the road," she said.

Gillece envisioned a project where the women would have a secure and nurturing environment in which they could be with their infants. She began meeting with the organizations that would one day become instrumental in addressing the needs of the women inmates and their babies, including the University of Maryland Medical Center, the Department of Housing and Urban Development (HUD), and the Maryland Department of Public Safety and Correctional Services.

In 2001 Gillece and colleague Andrea Karfgin, Ph.D., worked in partnership with the Baltimore City Mayor's office to obtain a $1.5 million grant from the Substance Abuse and Mental Health Services Administration to launch the project, but they also relied on other funding sources.

She dubbed the project Tamar's Children, after a project she established in the late 1990s to treat women inmates for trauma and substance use disorders.

As part of the this project, which is known as Tamar, Gillece and Karfgin, who was then its director of clinical services, developed a trauma-treatment protocol for use in the Maryland prisons and jails.

Tamar, Gillece explained, is a woman in the Old Testament who was raped by her half-brother. She ripped her clothing in disgrace and was never heard from again. "We named the program after the Tamars of today," Gillece said. "Tamar" also stands for trauma, addiction, mental health, and recovery.

Many of the women who participate in the Tamar projects have been convicted of nonviolent crimes such as prostitution and various drug offenses, and they have related histories of neglect, physical and sexual abuse, and addiction, Gillece said.

"Our goal in establishing Tamar's Children," she continued, "was not only to treat the inmates' trauma and substance use disorders but also to work with them to develop healthy attachments with their babies."

Instead of serving out their sentences in a Maryland prison or jail, women inmates who are in their third trimester of pregnancy and deemed eligible for the program are brought to a community correctional facility located in a converted convent at St. Ambrose Church in Baltimore. Here, the women inmates receive intensive individual and group counseling each day.

Women can enter Tamar's Children several ways, Gillece explained. While in jail, some are granted special leave status from the Maryland Department of Public Safety and Correctional Services, and others enter the program as a condition of probation or parole.

Gillece said many Maryland judges are supportive of the program, and work with Tamar's Children staff to establish sentences that fit into the program's framework—women must participate in the program for at least a year.

please see ***Prison Program*** *on facing page*

Mothers Taught Parenting Skills In Innovative Prison Project

After multiple arrests and years of drug addiction, one woman said she "is ready to live life" after serving time under a program that focuses on improving mental health for mothers and babies.

BY EVE BENDER

Monique was halfway through her pregnancy and serving time in the Baltimore City Detention Center when a judge recommended her for the Tamar's Children program.

"I didn't have anyone who could take my baby, and I was getting ready to repeat history," she told *Psychiatric News*.

Tamar's Children is a multiagency collaboration designed to help pregnant women who are incarcerated in Maryland to overcome problems related to trauma and substance abuse and to develop healthy relationships with their children (see facing page).

By the time Monique was 20 years old, she had three children. By the time she was 21, they had been removed from her custody due to her addiction to crack cocaine and heroin.

"I felt I had nothing to live for," she said. She also had problems trusting others and said "shame and guilt kept me using" and prevented her from seeking help.

But after entering the program and giving birth to her baby, Daiquan, she developed a new outlook on life. "I feel good about myself—I'm not leaving this program the same person I was when I came in," she said.

In addition to helping her recover from trauma and substance abuse, she said, "the program helped me to be a good mother," she said. "If my son needs something, I know I'll be able to provide it to him."

Through Tamar's Children, Monique acquired her GED. She said she is planning to attend college and become a substance-abuse counselor.

"I want to help people in return for the help that was given to me," she said. "Maybe I can help other addicts so they don't have to experience the pain I did."

On the eve of leaving the facility to return to her home in Baltimore—she will return for six months to attend Circle of Security groups—Monique became reflective about the days ahead.

"I feel good about myself—I'm not leaving this program the same person I was when I came in," says Monique, who is holding her son, Daiquan.

"I do have fear about being on my own, but I know it's healthy to have fear," she said. "That fear will keep me on the right track."

She described herself as "ready to live life, because I have never really lived before."

When Monique encounters detractors, she responds with newfound confidence: "Some people look at those of us who have been incarcerated and think we can't change our lives around. . . , but if you are determined to change, you can do it. You just have to be strong." ■

Prison Program

continued from facing page

Tamar's Children groups are focused on helping the women manage symptoms related to trauma such as flashbacks, recover from substance abuse problems, develop healthy relationships, and build self-esteem, for instance.

The inmates also receive comprehensive prenatal care, including educational services, through the University of Maryland department of obstetrics and gynecology, which is located nearby at the University of Maryland Medical Center.

Hugh Mighty, M.D., who is chief of obstetrics, gynecology, and reproductive sciences at the University of Maryland Medical System, is chair of the Tamar's Children Advisory Board.

When it's time for the women to deliver their babies, they are cared for by Mighty's staff. "Our women don't have to go to the emergency room in shackles," said Gillece. "They go right up to the maternity unit and are treated with dignity and respect."

"Anytime you have women who are incarcerated, there is stigma," Gillece continued. "Add that they have prostituted themselves, are pregnant, and addicted to heroin. These are not popular girls. Anywhere."

The birthing experience is a new one for many of the women—including those who are not first-time mothers, she noted. "Many of the women had been using drugs when they had their other babies and hadn't delivered without being high before—it is a whole new experience," she said.

Afterward, they return to the facility with their babies and begin the task of mothering.

What should be a chaotic scene—nearly 20 women toughened by years on the streets

please see ***Prison Program*** *on page 62*

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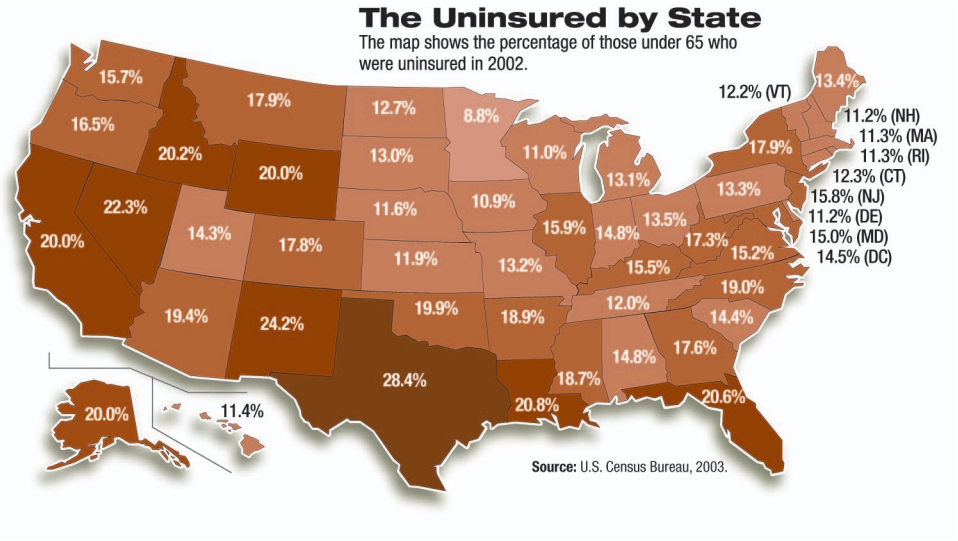
IOM Says Small Steps Won't Cure Health Insurance Crisis

Key principles for health system reform are that health care should be universal, continuous, affordable to individuals and families, affordable and sustainable to society, and promote access to high-quality care.

BY MARK MORAN



The lack of health insurance in many American communities is a problem that can no longer be ignored, and the federal government can and should seek to achieve universal health coverage by 2010.

So says a 16-member committee of the Institute of Medicine (IOM) in a recent report, "Insuring America's Health: Principles and Recommendations." In keeping with the title, the report outlines principles for achieving universal coverage and describes prototypical strategies for reform.

No matter what strategy is chosen, the problem requires a federal solution, and incremental fixes are no longer sufficient, concludes the Committee on the Consequences of Uninsurance. The committee includes health and public policy experts from the public and private sectors.

"The persistence of sizable uninsured populations in many communities in the United States has important local effects," according to the report. "These include (1) significant financial strain on health care providers and institutions that can lead to loss of valuable community resources, such as a trauma center or physician practices, and (2) redirection of funds to the uninsured away from core public health programs that address control of diseases and emergency preparedness."

The report also emphasizes, "The economic vitality of the nation is limited by the poorer health, premature death, and long-term disability of uninsured workers. The value in health years of life gained by providing coverage to everyone would almost certainly be greater than the additional cost of providing health care, at the level of the currently insured, to those who lack coverage."

The IOM also states that incremental improvements—from the Medicare and Medicaid programs enacted in the 1960s to serve elderly and needy populations, to the State Children's Health Insurance Program (SCHIP) enacted in the 1990s—have not closed the gap in coverage or addressed underlying problems in the nation's patchwork of public and private health care networks.

Committee co-chair Mary Sue Coleman, president of the University of Michigan, stressed the importance of federal involvement. "Lack of health insurance in the United States is a critical problem that can and should be eliminated," she said. "Achieving universal coverage will require federal leadership and support, regardless of

Mass. Physicians Back Single-Payer System

Nearly two-thirds of Massachusetts physicians support a national single-payer health care system, according to a survey published in the February 9 *Archives of Internal Medicine*.

Of 1,787 physicians, 904 (50.6 percent) responded to the survey. When asked which structure would provide the best care for the most people for a fixed amount of money, 63.5 percent of physicians chose a single-payer system; 10.7 percent, a managed care system; and 25.8 percent, a fee-for-service system.

The survey also found that 67 percent of respondents said they would accept a 10 percent reduction in fees in exchange for a "very substantial reduction" in paperwork.

The Kaiser Daily Health Policy Report, which cites the survey, is posted at <www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=22160&dr_cat=3>. ■

which strategy is adopted to achieve this goal."

The report, the sixth from the IOM in a series of reports on the nation's health care system, includes five principles to guide health reform strategies and outlines four prototypical reform strategies—discussing each strategy with respect to how well it addresses the five principles.

The five principles are that health care coverage should be universal, continuous, affordable to individuals and families, and affordable and sustainable to society and should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

The principles are based on evidence and conclusions reached in the committee's five previous reports, which documented the consequences of lack of health insurance. Among those consequences are the following:

> "The economic vitality of the nation is limited by the poorer health, premature death, and long-term disability of uninsured workers."

- About 18,000 unnecessary deaths occur each year due to a lack of health insurance.
- Only half of uninsured children visited a physician during 2001, compared with three-quarters of insured children. Lack of regular care can result in more expensive care for preventable or treatable conditions, and disruptions in learning and development.
- When even one family member is uninsured, the entire family is at risk for the financial consequences of a catastrophic illness or injury.
- Tax dollars paid for an estimated 85 percent of the roughly $35 billion in unreimbursed medical care for the uninsured in 2001.

The IOM report also describes four prototypical strategies for reform. Each has strengths and weaknesses, and the ideal strategy may be one that combines the strengths of all of them; but any of the strategies would be better than the status quo, according to the report.

These are the four prototypes:

- **Major public-program expansion and new tax credits.** Under this strategy, favorable tax treatment for employer-based private insurance would remain in place. Medicaid and SCHIP programs would be combined, and Medicare would be extended to 55-year-old individuals who pay a premium. Tax credits would allow moderate-income individuals to purchase private insurance.
- **Employer mandate, premium subsidy, and individual mandate.** Employers would be required to offer coverage and contribute to premiums, with a federal subsidy for employers of low-wage workers. Medicaid and SCHIP would be merged, and Medicare would remain as is. Individuals would be required to obtain coverage through employers, enrollment in a public program, or private purchase.
- **Individual mandate and tax credit.** Individuals would be required to buy health insurance for themselves and their families on the open market, supported by a federal tax credit. Medicaid and SCHIP would be eliminated, but Medicare would remain as is.
- **Single payer.** Everyone would be enrolled in a single, comprehensive benefit package, though individuals could purchase supplemental policies for non-covered services. The program would be administered by the federal government, but contractors and private health plans would review claims and process payments, as is now the case with Medicare. A "global budget" would be established. While Medicaid and SCHIP would be eliminated, Medicare enrollees would be folded into the new federal plan.

"Insuring America's Health: Principles and Recommendations" is posted online at <www.iom.edu/report.asp?id=17632>. ■

Trivedi Receives Spurlock Fellowship

Harsh Trivedi, M.D., the recipient of APA's 2004 Jeanne Spurlock Congressional Fellowship, began his fellowship in January in the office of Sen. Jack Reed (D-R.I.). Reed serves on the Health, Education, Labor and Pensions Committee (HELP) and on the HELP Subcommittee on Mental Health and Substance Abuse Services.

Trivedi recently completed a position as chief resident in his third year of adult psychiatry training at the Zucker Hillside Hospital, Long Island Jewish Medical Center.

He said that among the goals he hopes to achieve as a Spurlock congressional fellow are to better understand the policy-making process, learn how to become a more-effective advocate for psychiatric patients, and be involved in introducing legislation in the Senate to expand mental health services for children and adolescents.

"Another area of interest," he said, "lies in developing early intervention programs for children and adolescents and to increase mental health awareness and knowledge in the general public." ■

Depression Symptoms Vary From One Episode to Next

Psychiatrists should not assume that the symptoms that characterize a first episode of major depression will be the ones manifest in a second such episode.

BY JOAN AREHART-TREICHEL

Her name is "Tanya," and at age 16, she experienced a major depression. She has now made it to age 26 without experiencing another one.

Nonetheless, her chances of developing another major depression in the future are considerable, perhaps as high as 58 percent, research has suggested. And if and when that time comes, she may well sustain symptoms that differ from those she endured the first time around, a study reported in the February *American Journal of Psychiatry* found.

The investigation was headed by Maria Oquendo, M.D., an associate professor of clinical psychiatry at Columbia University.

Oquendo and her colleagues focused on 185 persons who were being treated for a major depressive disorder as inpatients at university hospitals in New York or Pittsburgh. The researchers assessed these individuals with the 24-item Hamilton Depression Rating Scale to identify their symptoms, then contacted them three months, one year, and two years later to learn whether they had experienced another major depression. If the subject had developed a second depressive episode, the researchers assessed them again with the Hamilton scale.

At the end of two years, 78 of the 185 subjects had once again incurred a major depression, so the investigators were able to compare the symptoms of the two major depression episodes.

The symptoms that the 78 had experienced the first time were usually not those they encountered the second time, the scientists found. The most robust, although still weak, links across episodes were for anxiety and suicidal behavior. Even the depression subtype—melancholic, psychotic, or atypical—was likely to differ the second time, the investigators discovered.

This "lack of robust consistency of symptoms or depressive subtype across episodes is striking," Oquendo and her team concluded in their study report, "in that, by definition, we *require* subjects to meet criteria for depression. . . increasing chances of finding an association."

The study report, "Instability of Symptoms in Recurrent Major Depression: A Prospective Study," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/2/255?>. ■

DSM-IV Can Identify Preschoolers Whose Disruptive Behavior Is Atypical

A study appears to support the validity of *DSM-IV* criteria for two childhood psychiatric disorders.

BY JOAN AREHART-TREICHEL

Two- to 5-year-old children aren't exactly known to be paragons of virtue. Temper tantrums, sassing, balking, kicking, and other socially unacceptable behaviors are sometimes the rule. Thus, psychiatrists have been debating whether, when it comes to very young children, *DSM-IV* criteria for oppositional defiant disorder and conduct disorder can be used to pick out children who are truly disturbed from children who are misbehaving.

The debate appears to be over, a preliminary study reported in the February *American Journal of Psychiatry* suggests. The study was conducted by Kate Keenan, Ph.D., and Lauren Wakschlag, Ph.D., assistant professors of psychiatry at the University of Chicago.

Their subjects were 79 preschoolers referred to a psychiatry clinic for behavior problems and 50 preschoolers who had not been so referred. The subjects in both groups were similar in age, gender, race, and socioeconomic status.

The researchers assessed the number of symptoms of *DSM-IV* oppositional defiant disorder and of *DSM-IV* conduct disorder in each subject and compared the rates of symptoms for subjects in the referred group with the rates of symptoms for subjects in the nonreferred group.

Only one (2 percent) of the nonreferred subjects met criteria for oppositional defiant disorder, compared with 47 (60 percent) of the referred subjects, the researchers found. Only one (2 percent) of the nonreferred children met criteria for conduct disorder, compared with 33 (42 percent) of referred children.

"Our results [thus] provide preliminary evidence for the discriminative validity of *DSM-IV* oppositional defiant and conduct disorder symptoms in preschool children," Keenan and Wakschlag concluded. In other words: "The *DSM-IV* nosology appears to be a valid diagnostic system for discriminating between typical and atypical disruptive behaviors in preschool children."

The study report, "Are Oppositional Defiant and Conduct Disorder Symptoms Normative Behaviors in Preschoolers? A Comparison of Referred and Nonreferred Children," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/2/356?>. ■

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Schizophrenia Patients Empowered To Take Charge of Illness

Patients with schizophrenia at one St. Louis hospital are learning how to cope with troubling symptoms and build their support networks as they are guided through the continuum of care.

BY EVE BENDER

Staff at Christian Hospital Northeast in St. Louis are empowering patients with schizophrenia through a comprehensive psychoeducation program aimed at helping them manage their symptoms and lead more productive lives.

The Schizophrenia Treatment and Education Program (STEPS) features a range of interactive classes tailored to the needs of patients with schizophrenia. Patients in the program learn how to manage stress, cope with troubling symptoms of their illness, and develop social skills, for example.

Garry Vickar, M.D., launched the program in 1985. He recognized that inpatients with schizophrenia and their families could benefit from accurate information about the disorder and up-to-date treatment strategies to combat its symptoms.

Vickar is medical director of the STEPS program and chair of psychiatry at Christian Hospital, a 460-bed general hospital in St. Louis. He is also immediate past president of the Eastern Missouri Psychiatric Society and is its representative to the APA Assembly.

"When I began to practice in 1976, families were being bombarded with the message that they were to blame for their relatives' schizophrenia," Vickar told *Psychiatric News*. He began to hold meetings for his patients and their families because he believed "it was important to educate patients and families about the medical model of the illness" in a way that was "less pejorative and guilt provoking for families," he explained.

He and his staff at the hospital finally had the opportunity to educate patients and families on a much larger scale with the advent of the STEPS program in 1985.

Since that time, patients with schizophrenia or schizoaffective disorder who are admitted to the hospital have been folded into the weekly schedule of STEPS courses and attend them on a voluntary basis.

Focus on Improved Functioning

As part of the program, master's-level mental health clinicians teach patients how to eat well and exercise, navigate a maze of social services, build support systems, and develop leisure activities.

There are also classes on how to manage stress and anger, build self-esteem, and develop coping skills.

In addition, volunteers bring trained dogs onto the unit for pet therapy once a week.

Goldie, a golden retriever, and Lee, a schnauzer, are a big hit with patients, according to psychiatric nurse Jan Roe, R.N., who has worked on the unit since 1987. "The patients love the dogs," she said. "The dogs bring them out of their shells."

One patient on the unit, Roe recalled, would not communicate with anyone. "But she began to communicate with the dogs," Roe said, and after that experience, "she began to open up with us."

STEPS staff also educate the families about schizophrenia in periodic workshops and in private meetings with patients, Roe said.

Partial-Hospital Program Used

After they are discharged from the hospital, patients are invited back to the unit to participate in the partial-hospitalization program, in which they sit in on the daily classes.

In addition, some patients join the STEPS aftercare program, which is extended to former inpatients as well as people with schizophrenia who have never been exposed to the program, Vickar said.

Garry Vickar, M.D.: "We believe in this program because we see how well it works."

In the aftercare group, which is offered on Wednesday evenings and is free of charge, patients offer support to one another and are free to address with staff any issues that concern them.

"Some patients have been coming to aftercare for years now," he said, noting that many patients in the aftercare program develop close and enduring relationships with staff.

Patients who come to the aftercare program often opt to join the National Alliance for the Mentally Ill North Club chapter, according to Vickar and Roe, through which they socialize during monthly outings to restaurants, movie theaters, and museums, for instance.

Vickar said he is gratified by the improvements made by many of the program's patients. He has seen patients, after leaving the program, move on to independent living situations, new friendships,

please see ***Schizophrenia*** *on page 49*

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Are Benzodiazepines Prescribed Properly to Substance Abusers?

When physicians are aware of a patient's substance abuse, some may decide that it is more important to treat the patient for anxiety.

BY MARK MORAN

Benzodiazepines are prescribed for patients with severe mental illness and co-occurring substance use disorder at a higher rate than for persons with severe mental illness alone—a prescribing pattern that would appear to fly in the face of APA guidelines.

In a retrospective study of benzodiazepine use among New Hampshire Medicaid beneficiaries, 62 percent of patients with schizophrenia and a co-occurring substance use disorder had been using benzodiazepines during the five-year period 1995-1999. This is compared with 54 percent for patients who had schizophrenia but no substance use disorder.

The rate of five-year benzodiazepine use among other mentally ill patients with and without a co-occurring substance use disorder was 75 percent versus 58 percent for bipolar disorder; 66 percent versus 49 percent for major depression; and 48 percent versus 40 percent for other psychiatric disorders.

The study, published in the February *Journal of Clinical Psychiatry*, examined Medicaid claims for 9,884 Medicaid beneficiaries aged 18 to 64 with schizophrenia, bipolar disorder, major depression, or other psychiatric disorders between 1995 and 1999. Rates and length of use and frequency of high potency/fast-acting prescriptions were compared for those with and without a claims-based substance use disorder diagnosis.

Study author Robin Clark, Ph.D., noted that APA's 1990 guidelines on benzodiazepines use caution against long-term use by patients with substance use disorders because of the addictive potential of these medications.

Those guidelines recommend that physicians use the medications for brief treatment but conclude that "risks of chronic toxicity, especially cognitive impairment, true physiological dependence, and discontinuance symptoms, are all more likely under the following conditions: (1) high dose, (2) daily dosing of more than four months' duration, (3) advanced age, (4) current use or history of sedative hypnotic and/or alcohol dependence, and (5) use of high-potency, short half-life benzodiazepines."

"It's clear from our study that the guidelines are not being followed," Clark told *Psychiatric News*. "What needs to change, the prescribing patterns or the guidelines?"

He is director of research, design, and methods at the Center for Health Policy and Research at the University of Massachusetts Medical School.

Clark said the study does not explain why physicians appear to be prescribing benzodiazepines so extensively to patients with substance use disorders. Nor is it clear from the study, Clark said, whether patients in the study were primarily being treated by psychiatrists, primary care providers, or other physicians.

"Benzodiazepines are a very important classification of medication, and we are not suggesting that they should never be prescribed for people with substance use disorders," he said. "But it seems that physicians, if they know about the substance abuse, are weighing the alternatives and deciding that it is more important to treat the anxiety."

The study, "Benzodiazepine Prescription Practices and Substance Abuse in Persons With Severe Mental Illness," is posted online at <www.psychiatrist.com/abstracts/200402/020401.htm>. ■

Schizophrenia

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and full-time work. "We believe in this program because we see how well it works," he said.

But perhaps the best testament to the success of the program lies in its outcomes.

A recent study conducted by Carol North, M.D., and Dana Downs, M.S.W., compared STEPS participants with schizophrenia patients receiving standard inpatient care. STEPS participants, the researchers found, had significantly fewer rehospitalizations than those in the control group, which translated into reduced treatment costs.

North is a professor of psychiatry at Washington University in St. Louis and Downs is a clinical research coordinator there.

Vickar presented program data at the APA Institute on Psychiatric Services in Boston in October, his eighth presentation on the STEPS program at that meeting.

The researchers plan to submit the data for publication this year.

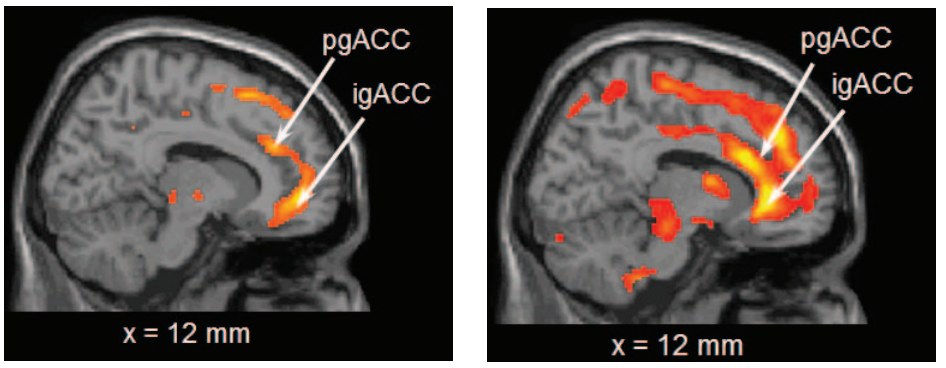
Vickar said he thinks the program can be replicated in other settings. "I think this program can work anywhere. It's a matter of having staff who are dedicated to working with patients with schizophrenia."

He said he hopes that if patients take nothing else away from their learning experience as participants in the STEPS program, they at least understand that schizophrenia is an illness. "This disease is not their fault." ■

Treatment of Meth Users Should Target Mood-Disorder Symptoms

Detailed new images offer a striking portrait of the biological underpinnings of mood symptoms in methamphetamine users during acute withdrawal.

BY JIM ROSACK



Brain imaging shows higher metabolic activity (brighter, larger areas of orange and red) in the anterior cingulate cortex of a methamphetamine user (right) compared with a control subject (left). The higher the brain activity, the higher was the patient's depression score.

New positron emission tomography (PET) images of brain activity in patients in acute withdrawal from methamphetamine use show changes strikingly similar to those of patients with depressive and anxiety disorders. Researchers believe the new images offer biological evidence that mood symptoms must be assessed—and adequately treated—to treat methamphetamine abuse effectively.

"This is graphic biological evidence that mood disorder is a very important problem in acutely abstaining methamphetamine users," lead author Edythe London, Ph.D., told *Psychiatric News*. London is a senior research scientist at the University of California at Los Angeles (UCLA) Neuropsychiatric Institute and a professor of psychiatry and pharmacology at the David Geffen School of Medicine at UCLA.

The research, funded by the National Institute on Drug Abuse (NIDA), appeared in the January *Archives of General Psychiatry*.

Should Depression Be Targeted?

"Treating methamphetamine addicts typically focuses on addressing drug craving," London said. "These PET images pinpoint, for the first time, abnormal brain activity that is closely linked to symptoms of depression and anxiety. Targeting these complicating conditions as part of a more comprehensive treatment program may improve success rates for methamphetamine addiction therapy."

"CBT requires focused attention, learning, understanding, and self-control, all of which are difficult to accomplish if the mood disorder is not taken care of."

London and her team used PET to examine glucose metabolism in seven brain areas known to regulate emotion, motivation, and behavior: the brain's orbitofrontal, cingulate, lateral prefrontal, and insular cortices, as well as in the amygdala, striatum, and cerebellum. Each patient participating in the study underwent imaging and completed the Beck Depression Inventory to measure self-reported symptoms of depression and the State-Trait Anxiety Inventory to measure self-reported symptoms of anxiety. Seventeen methamphetamine abusers in an inpatient detoxification program were compared with 18 control subjects.

Mood Symptoms Reported

London found that the patients who were four to seven days out from their last use of methamphetamine gave significantly higher ratings of their symptoms of depression and anxiety compared with the control group. None of the patients met full diagnostic criteria for major depressive disorder, yet the depressive symptoms of the methamphetamine users were not minimal. The average BDI score for methamphetamine users was 9.5, compared with 1.1 for control subjects.

Anxiety scores were intriguing as well, London noted, showing significant increases for both state and trait anxiety in methamphetamine users compared with control subjects.

PET imaging of brain metabolism patterns clearly demonstrated differences between methamphetamine users and control subjects, particularly in the anterior cingulate gyrus and the insula (see images above).

Interestingly, London said, there was enough variation in brain metabolism of particular areas between the individuals who were in acute withdrawal from amphetamine to plot the relationship between activity of an individual brain region and self-

reported symptoms of depression and anxiety.

"In fact, there were very strong relationships with activity in the limbic regions, such as the anterior cingulate and amygdala, and symptoms of depression, such that the higher the activity, the higher the depression score," London said, "and there were also strong relationships between activity in the insula and anxiety, such that the lower the activity in the insula, the higher the state and trait anxiety measures."

London described treatment of methamphetamine abusers as "kind of a moving target." When a patient first comes into a treatment center or program, London said, "it is when they just ran out of money and cannot pay for their next hit. So they feel awful. But those mood and anxiety feelings will be different in three weeks, two months, one year than they are at intake. So one of the messages of this study is that when the methamphetamine user first presents for treatment, the mood disorder is a big, big problem that must be addressed."

The mainstay of treatment for methamphetamine abuse has been cognitive-behavioral therapy, which London said is difficult if not impossible to begin at intake, because of the mood-disorder symptoms.

NIDA Director Nora Volkow, M.D., noted in a press release, "Currently, no medication exists to treat abuse or addiction to amphetamines or amphetamine-like compounds; however, drug counselors and other health professionals have successfully used behavioral interventions to treat addiction. Treatment outcomes may improve if associated mental conditions are addressed concurrently with addiction."

The mood-disorder symptoms create an acute barrier to treatment, London told *Psychiatric News*. "CBT requires focused attention, learning, understanding, and self-control," she explained, "all of which are difficult to accomplish if the mood disorder is not taken care of. [Patients] need to be told that. That acknowledgement [by treating clinicians] could be therapeutic in and of itself."

London hopes to follow up the study with a look at how mood symptoms and brain activity change over time, as methamphetamine users go through a treatment program.

"Then we could define a therapeutic regimen that takes into consideration where the patient is at different stages of withdrawal."

An abstract of the article, "Mood Disturbances and Regional Cerebral Metabolic Abnormalities in Recently Abstinent Methamphetamine Abusers," is posted online at <http://archpsyc.ama-assn.org/cgi/content/abstract/61/1/73>. ■

Morning Headaches May Signal Depression, Anxiety Disorders

A large-scale study finds a strong association between morning headaches and depressive and anxiety disorders.

BY EVE BENDER

People who have a depressive or anxiety disorder are at least twice as likely to wake up with a headache in the morning as those without the disorders, according to a study of more than 18,000 subjects in Europe.

In fact, according to the study's principal investigator, Maurice Ohayon, M.D., Ph.D., the headaches may be a "signal symptom" of major depression.

Ohayon sought to determine the prevalence of "chronic morning headaches," or headaches experienced upon awakening, in the general population. He then explored whether the headaches were associated with a number of variables, such as sociodemographic characteristics, sleep disorders, and psychiatric disorders.

Ohayon is director of sleep epidemiology at Stanford University.

In order to gather the data, interviewers called a random sample of 18,980 people over age 15 living in the United Kingdom, Germany, Italy, Portugal, or Spain from 1994 to 1999.

When questioning subjects about sociodemographic characteristics, sleep habits, and mental health, interviewers used Sleep-EVAL software, which Ohayon developed. The software includes diagnostic information derived from the *DSM-IV* and the *International Classification of Sleep Disorders*.

Ohayon determined that 7.6 percent of the sample, or 1,442 people, experienced morning headaches.

People with comorbid depressive and anxiety disorders had the highest chance of experiencing morning headaches; they were 3.5 percent more likely to experience the headaches as those without the comorbid psychiatric disorders.

Subjects with major depressive disorder alone were 2.7 times as likely to experience morning headaches as those without depression, and those with anxiety disorder alone were almost twice as likely to suffer from the headaches.

According to Ohayon, the headaches can be a somatic manifestation of depression. He also noted that the relationship goes both ways—if severe enough, the headaches can also cause a person to feel depressed.

He found that other variables associated with chronic morning headaches included insomnia, sleep-related breathing disorders, and a high level of stress.

Further research should focus on the nature of the relationship between chronic morning headaches and psychiatric disorders such as major depression, he told *Psychiatric News*.

An abstract of the article, "Prevalence and Risk Factors of Morning Headaches in the General Population," is posted online at <http://archinte.ama-assn.org/cgi/content/abstract/164/1/97?>. ■

Conduct Disorder, Alcoholism May Share Genetic Link

Two genetic regions—one on chromosome 19 and one on chromosome 2—appear to be complicit in childhood conduct disorder. The latter region is especially intriguing since it also seems to contribute to alcohol dependence.

BY JOAN AREHART-TREICHEL

Childhood conduct disorder has genetic inputs, various twin studies have revealed. In fact, genes may account for as much as 40 percent to 70 percent of the disorder, a Virginia twin study and an Australian twin study have suggested. But what specific genes might be at work here? Tatiana Foroud, Ph.D., an associate professor of medical and molecular genetics and psychiatry at Indiana University School of Medicine, and colleagues decided to search for an answer.

As they reported in the January *Molecular Psychiatry*, a genetic region on chromosome 19 and one on chromosome 2 look especially suspect.

During the 1990s, the Collaborative Study on the Genetics of Alcoholism was conducted to identify genes contributing to alcoholism. It included not just 1,227 individuals who were alcohol dependent, but at least two family members for each. As part of the study, all subjects aged 18 or older were interviewed using the Semi-Structured Assessment for the Genetics of Alcoholism (SSAGA). The SSAGA helps diagnose childhood conduct disorder through retrospective report of behavioral problems demonstrated before the age of 15. Thirteen percent of all these subjects met criteria for a childhood diagnosis of conduct disorder.

Foroud and her colleagues then decided to use from this study 114 sibling pairs concordant for childhood conduct disorder, in order to conduct their own investigation into the genetics of conduct disorder.

The researchers found that a particular genetic location on chromosome 19 yielded the strongest evidence of linkage with conduct disorder, and a particular genetic position on chromosome 2 turned out to have the next-strongest connection to the disorder.

The latter finding "is especially interesting," Foroud and her team pointed out in their study report, "because this region of chromosome 2 also has been linked to alcohol dependence. . . .[In short] the overlap of the linkage findings for alcoholism and conduct disorder on chromosome 2 supports the suggestion from twin studies that conduct disorder and alcohol dependence partially share a genetic liability. . . ."

Added Samuel Kuperman, M.D., director of child psychiatry at the University of Iowa School of Medicine and another study co-author, "I think this is an exciting preliminary study that may lead to some future identification of the genes in conduct disorder. . . .This study needs to be replicated in a sample of subjects that was not selected due to a strong family history of alcoholism. Also, it would be important to do this study prospectively with children to see whether children who have these genetic markers have conduct disorder or develop conduct disorder during their adolescence."

The study was funded by the National Institute on Alcohol Abuse and Alcoholism.

An abstract of the study, "A Genome-Wide Screen for Genes Influencing Conduct Disorder," is posted online at <www.nature.com/cgi-taf/DynaPage.taf?file=/mp/journal/v9/n1/abs/4001368a.html>. ■

Epilepsy Drug May Slow Progression Of Alzheimer's

Valproate may increase the expression of a protein that slows the cell death that neurons undergo in Alzheimer's. It may also inhibit production of an enzyme involved in production of neurofibrillary tangles.

BY MARK MORAN

A multisite, placebo-controlled trial funded by the National Institute on Aging will study the utility of valproate in prophylactically delaying the emergence of agitation or psychosis in outpatients with Alzheimer's disease.

A target dose of valproate at approximately 10-12 mg/kg per day will be tested in outpatients with probable Alzheimer's. They will be treated for 24 months, followed by a two-month washout.

The drug has long been used to treat epilepsy in children and adults and now is used for a number of indications, such as treating mania in bipolar I disorder.

The study is sponsored by the Alzheimer's Disease Cooperative Study (ADCS), through an agreement between the National Institute on Aging and the University of California at San Diego to develop trials for agents designed to ameliorate behavioral symptoms, improve cognition, slow the rate of decline, or delay the appearance of Alzheimer's.

The lead researcher in the study is Pierre Teriot, M.D., of the departments of psy-

*please see **Alzheimer's** on page 66*

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Prison Progress

I applaud the December 5, 2003, article titled "Report Sounds Alarm on Plight of Mentally Ill Inmates" highlighting "the abysmal conditions" inmates face in the penal system. However, I would like to call attention to the fact that some states have indeed made efforts to provide appropriate mental health services in their correctional facilities. The maximum security prison for women in which I work has a mental health unit fully accredited by both the Joint Commission on Accreditation of Healthcare Organizations and the American Correctional Association, and while we do not claim to provide treatment equal to what is available in the community, given the limitations relating to the institution's security requirements, real and imagined, I am nevertheless pleased to report that we have a hard-working staff including five psychiatrists (one full time, four half time), four clinical psychologists, five social workers, and nine nurses.

Still, the deplorable conditions reported in the article are not likely to be corrected by state lawsuits, moving as they do with glacial speed and not always resulting in remedial steps. It will take enlightened action by Congress, as urged by APA, to bring needed psychiatric and other medical treatment services to this country's prisons.

ABRAHAM L. HALPERN, M.D.
Bedford Hills, N.Y.

Editor's Note: The next issue of *Psychiatric News* will report on a conference led by APA President Marcia Goin, M.D., on the increasing number of mentally ill inmates with little or no access to care.

Single Payer No Solution

I read with interest the letter by Dr. Scott Mendelson, M.D., Ph.D., in the December 19, 2003, issue. He reported his disgust with the news that an HMO merger will lead to one of the CEOs' pocketing "nearly $335 million in the deal," when certainly this money could have gone a long way toward alleviating the pain and suffering of their subscribers. He pointed out that the HMOs make life miserable for practitioners by making it difficult to prescribe medications and collect monies due them.

All this is true, but I do not agree with his conclusion that "[w]e need a single-payer system." If there can be greed, dishonesty, poor allocation of resources, poor insight, and lack of foresight in big groups, why should we think that a single-payer system would be any better? Perhaps it is hope: we hope, we wish, we want to believe that there is a single-payer system out there to make all of these headaches go away. I don't believe it, however. I think there will be just as many headaches, and probably more, under a single-payer system—headaches that are hard to imagine right now.

What about a return to a more realistic look at our world? Excellent health care costs more. Instead of using HMOs in which the likes of $335 million is siphoned out of the system, what about some other method of allocating health care dollars? Perhaps the money should simply be put into investment accounts like medical savings accounts, which can be used only for specific health care costs but are in the hands of either the individual or a company medical benefits division. Surely we can think of other ways to deal with this problem rather than counting on a fantasy of how we would like the system to be easy, fair, and always funded.

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Social Responsibility

I recently completed more than 75 hours of continuing medical education (CME) as required by my state medical board to maintain my license to practice medicine. The courses varied in content from psychopharmacology, addiction medicine, and psychiatric aspects of HIV and hepatitis C to cognitive therapy.

Almost all the courses were well presented,

please see ***Letters*** *on page 66*

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.

Association News

Candidates Sought

APA is seeking candidates for a pilot program that will provide diagnostic evaluation of performance on an oral examination similar to Part 2 of the psychiatry boards. Only candidates who have failed the oral board (Part 2 of the ABPN exam) more than two times will be accepted.

For the fee of $500, participants will be evaluated on performance on a live patient interview and clinical vignettes by current and past board examiners. Participants will then be given detailed feedback on factors that interfered with their performance. Remediation is the responsibility of the participants.

The program will be held at SUNY Downstate in Brooklyn on May 22. Only 24 people can be accommodated. Participants will be chosen by lottery from the applications received by the April 1 deadline.

Those interested in applying for the program are asked to contact Nancy Delanoche by e-mail at ndelanoche@psych.org or by phone at (703) 907-8635.

community news

Prison Program

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sharing the same space, some with newborn infants, some in their last months of pregnancy, and most coping with heroin addiction and trauma—is anything but.

"There is all this hugging, fixing lunch for one another, and holding one another's babies," noted Karfgin, who is project director for Tamar's Children.

When problems do arise between the inmates, she added, they are addressed in group meetings led by one of the psychologists or social workers.

For six months, the women live on the unit with their babies. At the end of the six months, case managers working with the program transfer them to housing in the Baltimore area. The housing is funded by a HUD Shelter Plus Care Grant.

The women continue to come to the unit a few days each week for another six more months to attend Circle of Security groups, an attachment-based intervention developed by researchers based at the Marycliff Institute in Spokane, Wash., in the late 1990s.

Training Builds Attachment

The group fosters healthy mother-infant attachment by training mothers to become more sensitive to their infant's need to explore the world and return for security and comfort, and teaches them how to respond to these needs, Karfgin explained.

As part of their training, the women in the program watch videotapes of themselves interacting with their infants.

"The women can see how they miscue their babies and how their babies miscue them," she noted.

For instance, a child's movement toward her mother may be misinterpreted as a need for attention rather than a need for connection.

The groups also teach the mothers how to allow their children to regulate their own feelings. Sometimes, when the babies cry or act as though they are uncomfortable, the mothers get frustrated and try to get them to the point where they are laughing or smiling all the time. "The mothers learn to let the babies be themselves and learn how to be there with them."

Tamar's Children is now entering its second year, and 15 women are enrolled in the program, according to Gillece. Five of the women have moved into their own homes in the Baltimore area but return for group sessions, and all provide peer counseling and support to newer inmates who join the program.

According to Brian Hepburn, M.D., psychiatrist and director of the Maryland Mental Hygiene Administration, the program's focus on prevention is what makes it so successful.

"We're all concerned about what happens when infants are separated from their mothers and how that can impact [infants'] lives. This program addresses that issue. Here we have women in jail who have normally been separated from their babies—this is a population that, in many ways, people have given up on."

By helping them to bond with their infants, he continued, "the program disrupts the cycle that results in people ending up in jails or in children who, because of attachment problems, may be at higher risk for antisocial behavior later in life."

More information about Tamar's Children is available by contacting Joan Gillece, Ph.D., at (410) 724-3238 or Andrea Karfgin, Ph.D., at (410) 212-3660. ■

SSRIs

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beneficial medications that have helped millions recover from devastating illness.

In many ways, the hearing mirrored a similar advisory committee meeting in 1993, when the FDA considered the link between SSRI use and increased risk of suicide in adult patients. Ultimately, the agency decided that the data at that time did not support any increased risk. Critics charged the agency with ignoring the facts, and many present at the recent hearing invoked the stinging memory, imploring the agency not to ignore the issue again.

Disparate Data at Issue

For the first time, the FDA released at the hearing summaries of data sets it has been studying from 24 clinical trials involving the use of nine antidepressant medications in child and adolescent populations. The majority of those studies involve major depression (15); however, some data are from trials for obsessive-compulsive disorder (4), generalized anxiety disorder (2), social anxiety disorder (1), and attention-deficit/hyperactivity disorder (2) (see box on facing page).

Much of the hearing focused on the complicated review of these data and the FDA's ensuing conclusions—or to date, lack thereof. Agency officials noted from the outset that they do not have all the data they need to reach fully reasoned, evidence-based conclusions.

While acknowledging publicly for the first time that some of the data appear to indicate an increased risk of suicide, the "signal" is not clear and is not consistent from one clinical trial to another, even within clinical trials for a single medication. In addition, agency researchers said, the data are not similar from one drug to another, as one would expect them to be if these drugs are all pharmacologically similar.

"It is absolutely critical," emphasized Russell Katz, M.D., director of the FDA's Division of Neuropharmacological Drug Products, "that we get this right. The wrong answer, in either direction, could have profound consequences for public health."

APA's Position Heard

On that point, APA Trustee-at-Large David Fassler, M.D., a child and adolescent psychiatrist in Burlington, Vt., testified before the panel that "APA is concerned that the publicity surrounding this issue may frighten some parents and discourage them from seeking help for their children."

Fassler noted that "the most important point that I can make is that the biggest risk for a child with depression is to be left untreated."

The agency asked the joint advisory committee for its recommendations on several questions, including the committee members' expert opinions on the FDA's plans for an ongoing, in-depth analysis of the available data to define better the real

risk, if any, of suicidal thoughts and behaviors associated with pediatric use of SSRIs. In the interim, the agency asked, should the FDA "provide additional advice to practicing physicians regarding the use of these drugs," and if so, what should the advice be?

Potential agency actions include leaving the existing warning language intact, issuing stronger warnings, or requiring labeling stating that the medications are contraindicated in those under age 18, effectively banning their use in child and adolescent patients.

Fassler urged the FDA to "develop mechanisms to enhance access to data from clinical trials, including negative trials, as well as unpublished research. We believe that such access would facilitate scientific discussion and dialogue, and help physicians and parents make fully informed decisions about treatment options."

The agency is attempting to do just that. At an internal regulatory briefing last September, FDA officials concluded that the data they had available were simply not adequate to answer the questions at hand.

At that point, the FDA had summaries of clinical trial data on the efficacy and safety of paroxetine in children and adolescents and postmarketing data on adverse events for the first year following the granting of pediatric exclusivity to GlaxoSmithKline for Paxil. They did not yet have summary data on postmarketing adverse events for any of the other eight antidepressants in which they were interested.

It was clear that "a very broad net had been cast in trying to capture events of potential interest with regard to possible suicidality, and questions were raised about what many of these events actually represented," wrote FDA's Laughren in a background briefing to advisory committee members.

The data were so incomplete and contradictory that the agency decided it needed to start from scratch. The FDA has since requested from the makers of the nine antidepressants "patient-level data"—that is, individual (although depersonalized) data—for each participant in each clinical trial conducted for each antidepressant tested to treat child and adolescent depression.

These data will be provided to a group of suicidality experts, coordinated through Columbia University, so that all events noted for each individual can be reclassified for risk of suicidal thoughts or behaviors. This large undertaking, the agency hopes, will be completed by late summer. After the expert analysis is complete, the FDA will convene a second joint advisory committee meeting to determine what regulatory actions should or should not be taken.

In part two,* Psychiatric News *will take a detailed look at the data and what experts think the data show about the risk of suicide connected to SSRIs. Also, competing explanations of why the FDA is taking so long to reach its conclusion will be discussed. ■

SSRI, Suicide Link Called Weak

A week before the FDA's contentious hearing on SSRIs and child and adolescent suicidal behaviors, the American College of Neuropsychopharmacology (ACNP) released a preliminary report at a Washington, D.C., press briefing concluding that popular antidepressant medications do not increase suicidal behaviors in patients under age 18 with depression.

"The evidence linking SSRIs to suicide is weak," said J. John Mann, M.D., co-chair of the ACNP task force examining the issue and a professor of psychiatry at Columbia University College of Physicians and Surgeons. Mann is also chief of neuroscience at the New York State Psychiatric Institute.

"There are strong lines of evidence in youth—from clinical trials, epidemiology and autopsy studies—that led the ACNP task force to conclude that SSRIs do not cause suicide in youth with depression."

The ACNP task force reviewed a subset of the clinical trial data available to the FDA (see story on page 1)—both published and unpublished—on the use of SSRIs in children and adolescents with depression. The task force was formed last September following British regulators' warnings to physicians in May 2003 not to prescribe SSRIs to patients under the age of 18. British regulators based their decisions on a significantly broader database than that which was available to the ACNP. The FDA issued weaker warnings in June 2003 noting the controversy and advising close monitoring of any patient under 18 taking SSRIs.

"The most likely explanation for the episodes of attempted suicide while taking SSRIs is the underlying depression, not the SSRIs," said Graham Emslie, M.D., co-chair with Mann on the task force and chief of the division of child and adolescent psychiatry at the University of Texas Southwestern Medical Center at Dallas. "The potential benefits of SSRIs outweigh the risks."

Mann, who has devoted the last 30 years to the study of youth suicide, noted that suicide attempts and suicidal ideation in youths with depression is common, but completed suicide is rare. Unfortunately, he said during the press briefing, the link between suicidal ideation or attempt and actual suicide completion is highly complex and not well understood. What is known is that "kids who think about it or attempt it are not the same as those who complete it. There may be a link between what I would refer to as failed suicides and completion."

A failed suicide, he noted, is a serious attempt that would have led to the patient's death if medical intervention had not occurred.

The ACNP task force members emphasized that the current data appear to be contradictory, and it is difficult to draw conclusions on a drug's efficacy in pediatric depression, for example, when three clinical trials are available, with one trial showing robust efficacy, a second showing small efficacy, and the third showing no statistical difference from placebo. The differences among individual trial results, the researchers said, is likely due to differences in methodology and data reporting.

ACNP is strongly urging that all data held by pharmaceutical companies or the FDA be made available publicly so that ACNP and others can conduct complete, independent evaluations.

A copy of the executive summary of the ACNP report is posted online at <www.acnp.org>.

Diabetes Risk

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the issue as well as pertinent animal studies.

The panel's deliberations were expected by many to be controversial from the start.

Last September the FDA required the manufacturers of all six second-generation drugs to relabel their products, adding common language stating that the drugs carry risk of metabolic side effects, including changes in glucose metabolism and lipid metabolism. Significantly, without directly saying so, the FDA appeared to put all of the six drugs on equal footing with regard to their risk of treatment-emergent diabetes (*Psychiatric News*, October 17, 2003).

Clinical evidence, however, has long suggested otherwise, and the panel's statement dutifully notes this issue. (In fact, Pfizer recently submitted a supplemental new drug application, based on newly analyzed postmarketing data on ziprasidone. The application requests the FDA to approve wording for the Geodon label that in part acknowledges its apparent lack of metabolic side effect.)

"The six currently available SGAs vary in their efficacy, formulation, biochemistry, receptor binding, and side-effect profiles," the consensus statement says. It goes on to say that the prevalence of both diabetes and obesity appear to be 1.5 to 2.0 times higher in patients with schizophrenia and affective disorders than in the general population. However, "whether this is a function of the illness itself versus its treatment is unknown."

The panel links the risk of treatment-emergent dysfunction in glucose metabolism to the antipsychotic medications' propensity to cause weight gain. Because the liability for weight gain varies among the six drugs, the risk for diabetes also varies between among them, the statement concludes.

"Despite limitations in study design, the data consistently show an increased risk for diabetes in patients treated with clozapine [Clozaril] or olanzapine [Zyprexa] compared with patients not receiving treatment with first-generation antipsychotics or other second-generation antipsychotics."

The risks associated with risperidone (Risperdal) and quetiapine (Seroquel) are "less clear," the statement says, noting that some studies show increased risk for diabetes associated with these two drugs, while other studies do not.

Lastly, the two most recently introduced medications—ziprasidone (Geodon) and aripiprazole (Abilify)—"have relatively limited epidemiological data," but clinical trial data indicate little or no risk for diabetes.

Schedule for Monitoring Patients On Second-Generation Antipsychotics*

Drug	Suicide attempt	Completed suicide	Suicide ideation	12 weeks	Quarterly	Annually	Every 5 years
Fluoxetine	34	6					
Sertraline	10	-				X	
Citalopram	7	-		X	X		
Paroxetine	5	1				X	
Venlafaxine	4	-		X		X	
Bupropiion	3	-		X		X	
Fluvoxamine	2	-		X			
Escitalopram	1	-					X

The differentiation of the six medications—which conflicts with the FDA's earlier stance—drew an immediate response from Zyprexa-maker Eli Lilly and Co. In a press release, the company blasted the consensus statement, saying the company "does not agree with the controversial conclusion. . . , which states that second-generation antipsychotics differ in their diabetes risk profiles." Lilly noted the FDA's own warning language says that "precise risk estimates for hyperglycemia-related adverse events in patients treated with atypical antipsychotics are not available."

Lilly said, however, that the company agrees with the majority of the consensus statement, including the call for baseline screening and follow-up monitoring for patients taking SGAs.

The consensus panel notes that despite the adverse effects associated with these medications, great clinical benefit has been derived from them.

However, "the risks of obesity, diabetes, and dyslipidemia have considerable clinical implications in this patient population and should influence drug choice." A careful risk-benefit analysis must be done for each patient, the statement says, and both physicians and patients would benefit from the continued availability "of a broad array of therapeutic agents."

The statement urges clinicians who prescribe these agents to assess and monitor key indicators of individual patients' baseline risk for the development of metabolic adverse effects. A thorough family history must be taken, and patients' weight, waist circumference, and blood pressure recorded. In addition, baseline values must be established for the patient's fasting plasma-glucose level and fasting lipid profile (see table above).

"These assessments," the statement says, "can determine if the patient is overweight (BMI ≥25.0-29.9) or obese (BMI ≥30.0), has pre-diabetes (fasting plasma glucose of 100-125 mg/dl) or diabetes (fasting plasma glucose ≥126 mg/dl), hypertension (blood pressure >140/90 mmHg), or dyslipidemia."

If any of the above are present, the statement stresses, appropriate treatment must be initiated, including referral to specialists.

The statement includes a monitoring schedule for periodic assessment of glucose, lipid, and blood pressure levels over the long term. If a patient gains more than 5 percent of his or her initial weight while taking an antipsychotic, the statement strongly urges clinicians to consider switching the patient to a medication with less of a weight-gaining liability. A switch should also be considered if a patient develops treatment-emergent worsening of glucose or lipid levels while taking an SGA.

In addition, the statement calls for significantly increased research efforts to help answer key questions, such as, Are there early treatment factors that could predict developing problems? If so, what are they?

The consensus statement is posted online at <http://care.diabetesjournals.org/cgi/content/full/27/2/596>. ■

JANSSEN RISPERDAL

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and all had direct implications for my daily clinical practice as a psychiatrist. Despite the repeated mantra of "supported by an unrestricted educational grant from _____ Pharmaceuticals," however, it seemed to me the drug industry played a not-so-covert role. I am not against the pharmaceutical industry, nor am I averse to using psychotropic medications in my work. Obviously the days of psychotherapy as the mainstay of psychiatry are history, and I am not suggesting a nostalgic return to yesteryear.

My question is this: What is the role of psychiatry in today's society? What are our moral obligations? Never in more than 75 hours of CME did anyone raise these and other questions such as, Why are so many people addicted to drugs and alcohol? Why are so many suffering from sexual abuse and posttraumatic stress disorder? Why are our prisons filled with mentally ill people? How can we spend billions on weapons and wars and so little on health care, especially mental health?

I believe it is our leaders who inspire us and set the moral tone. How do we tell our children that drugs are bad when the tobacco and alcohol industry are government subsidized? How do we explain that the richest, most powerful country in the world has millions of citizens who lack basic health care and live in poverty?

There are no role models currently in positions of power. The last leader I can respect is President Jimmy Carter. Even now, he continues to travel the world, quietly promoting morality and decency.

Enough ranting! Do we as psychiatrists have a responsibility to influence our country's morality? We have the unique privilege to see life as lived by our patients and comprehend human behavior. It is not enough to see them as diseases requiring therapy.

It doesn't have to be this way. I lived and worked for more than 30 years in Canada. Health care for all is taken for granted there. Sure, there are problems, but I believe the Canadian system is less costly and superior to that of the United States. Malpractice premiums are cheaper. People found with small amounts of marijuana receive a fine, similar to a parking ticket, rather than a criminal record. Canada allows openly gay individuals to serve in the military and is acknowledging that gays can legally marry without society being destroyed. The recently retired prime minister, Jean Chretien, used his power to promote "liberal" values.

As physicians—and psychiatrists in particular—we need to respond to the role society plays in mental illness and find how all those unhappy synapses we keep medicating get triggered.

PETER UHLMANN, M.D.
Crownpoint, N.M.

clinical & research news

Alzheimer's

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chiatry and neurology at the University of Rochester Medical Center.

Approximately 300 participants from 25 to 35 centers in the United States will be enrolled.

Alexander Auchus, M.D., clinical director of the University Hospital Memory and Aging Center at Case Western Reserve University School of Medicine and University Hospitals of Cleveland—a participating research site—told *Psychiatric News* that the study represents a novel clinical-trial strategy to assess both prospective "prophylactic" therapy for psychopathology in Alzheimer's and an approach that may slow the disease once it has already begun.

Auchus explained that valproate may work in several ways to protect against Alzheimer's or slow its progression. One way is by increasing the expression of a protein, bcl2, which is known to slow "apoptopsis," the self-induced cell death that neurons undergo in Alzheimer's.

Another way is by inhibiting production of the enzyme Gsk3b, which is believed to be involved in the production of neurofibrillary tangles, a hallmark of Alzheimer's.

"When we began to look at valproate in the laboratory, we were amazed to see that this simple drug blocked several key molecular events that we know are involved in the progression of Alzheimer's," Auchus said. "We are eager to learn whether these neuro effects that valproate exhibited in the laboratory will also occur in Alzheimer's patients." ■

government news

APA Testimony

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the bill by a two-vote margin.

The fate of domestic-partner benefits in the Old Dominion hinges on the vote of the state Senate. Virginia's legislative session ends March 16; if the Senate does not act by then, the bill will die.

William Kocol, a spokesperson for the nonpartisan advocacy group Equality Virginia, which lobbies for equal rights for gays and lesbians in the state, noted that the bill will likely find the Senate more receptive than the House, so the bill has a good chance of reaching the desk of Gov. Mark Warner (D), who has been a strong supporter of gay rights and has indicated he will sign such legislation.

Scully has also written a letter to the chair of the Virginia Senate committee to which the bill has been assigned, urging him to support the relaxation of the insurance restriction. Appealing to Virginia's reputation as a very business-friendly state, Scully said, "From a business perspective, we are now at a competitive disadvantage to professional associations in Maryland and D.C., which are able to offer domestic-partner benefits. Such benefits are inexpensive, but pay off handsomely in terms of productivity and morale."

Scully added, "APA has been hindered by this unwarranted intrusion into how it competes in the employment marketplace."

Scully also noted that such a restrictive law just adds to the number of Virginians compelled to go without health insurance.

The text of the bill, HB 1016, is posted online at <http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+HB1016>. ■