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Association News

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Members Choose Sharfstein As APA's Next President-Elect

APA's 2004 election was the first to reflect the Board of Trustees' downsizing plan, which was approved by APA members in last year's election.

BY CATHERINE F. BROWN

Steven S. Sharfstein, M.D., of Baltimore was chosen by APA members to be their next president-elect for the term beginning in May. He defeated Jagannathan Srinivasaraghavan, M.D. (Dr. Van), of Anna, Ill., with 66.5 percent of the vote.

Sharfstein, who is currently APA's senior vice president, is president of the nonprofit Sheppard Pratt Health System in Baltimore and clinical professor and vice chair of the department of psychiatry at the University of Maryland School of Medicine. He served as APA secretary from 1991 to 1995 and is a former APA deputy medical director.

Srinivasaraghavan is professor and chief of the Division of Community and Public Psychiatry at Southern Illinois University School of Medicine and medical director of the Choate Mental Health Center in Anna, Ill. He is also the Caucus of Asian-American Psychiatrists' representative to the APA Assembly and a member of the Council on Social Issues and Public Psychiatry.

Sharfstein told *Psychiatric News* that he plans to focus his presidency on advocating for patients and the profession of psychiatry, as well as on "the quality of what we offer to all Americans." He exhorted other APA members to join him in this work and pointed out the need for nonmember psychiatrists to make APA's voice stronger by becoming members.

"APA is the premier professional organization representing psychiatric medicine and as such the most important voice to advocate for our patients and our professional values," he said. "From our increasingly effective treatments based on the expanding science of psychiatry to public health and public policy, APA must lead for us all. Psychiatrists need to become more active in this advocacy role. They need to belong to APA and participate at the community, state, and national levels."

In one of the two three-way races in this year's election, Carolyn Robinowitz, M.D., of Bethesda, Md., defeated Albert Gaw, M.D., of San Francisco and Patrice Harris, M.D., of Decatur, Ga., for the office of

please see ***Election Results*** *on page 80*

APA President Marcia K. Goin, M.D. (right), talks with (from left) Henry Steadman, Ph.D., president of Policy Research Associates; incoming APA President-elect Steven Sharfstein, M.D., and Henry Weinstein, M.D., chair of APA's Corresponding Committee on Jails and Prisons.

APA Convenes Conference On Jail-Diversion Programs

APA President Marcia K. Goin, M.D., meets with other experts to discuss whether jail-diversion programs reduce recidivism and are less expensive than incarceration. See related column on page 3.

BY CHRISTINE LEHMANN

It is often said that you can judge a society by how well it treats its most vulnerable members.

If that's true, this country deserves harsh judgment for its inhumane practice of criminalizing people with mental illnesses: they receive inadequate mental health treatment and are often placed in isolation, which exacerbates their illness.

A more humane approach is to fund more community treatment programs to increase access to mental health care, according to APA leaders and representatives of mental health policy, research, and advocacy groups at a conference convened by APA President Marcia K. Goin, M.D., last month. She chaired the conference with APA incoming president-elect Steven Sharfstein, M.D., in conjunction with APA's Corresponding Committee on Jails and Prisons.

Other participants represented several organizations including the federal Center for Mental Health Services, National GAINS Center for People With Co-Occurring Disorders in the Justice System, National Association of State Mental Health Program Directors, Bazelon Center for Mental Health Law, and Council of State Governments.

The conference theme was the fiscal implications of criminalizing people with mental illnesses. "We could be more persuasive in advocating for increased funding for community treatment and diversion programs if we had data showing that it is more cost-effective than treating and maintaining people with mental illnesses in jails," Goin explained.

People with mental illnesses make up at least 16 percent of inmates in U.S. prisons and jails compared with 4 percent to 5 percent of the general population, ac-

please see ***Jail Diversion*** *on page 83*

Suicide-Related Reports to FDA

Drug	Suicide attempt	Completed suicide	Suicide ideation	Self-mutilation	Total
Fluoxetine	34	6	-	-	40
Sertraline	10	-	2	-	12
Citalopram	7	-	-	-	7
Paroxetine	5	1	-	1	7
Venlafaxine	4	-	-	1	5
Bupropion	3	-	-	-	3
Fluvoxamine	2	-	-	-	2
Escitalopram	1	-	-	-	1
Mirtazapine	1	-	-	-	1
Nefazodone	0	-	-	-	0
Total	**67**	**7**	**2**	**2**	**78**

Source: Food and Drug Administration

Adverse-event reports received by the FDA in the first three years after each drug entered the marketplace rarely resemble those seen in clinical trials. See page 2.

Data Fail to Answer Key Question About SSRIs' Suicide Risk

The data are neither "straightforward" nor conclusive, says the FDA, but contain a "signal" worth pursuing. This second of a two-part series takes a detailed look at the evidence connecting SSRIs with suicidal thoughts and behaviors in children and adolescents.

BY JIM ROSACK

It is a project of daunting scope, by anyone's standards: a comprehensive review of data on nine medications collected during 24 clinical trials involving more than 4,000 children and adolescents. Officials at the U.S. Food and Drug Administration (FDA) believe the task is critical to confirming whether apparent increases in rates of suicidal and self-harming thoughts and behaviors observed in those clinical trials are truly tied to the antidepressant medications that were being studied.

It is a deceptively simple question—either the drugs are associated with increased rates or not. Yet, despite more than 12 years of controversy and study, the question remains unanswered by the agency. For the first time, however, the FDA revealed during a public advisory committee meeting last month on the subject significant amounts of data that the agency has been analyzing and made its case for why FDA officials have yet to answer the critical question definitively *(Psychiatric News*, March 5).

According to agency officials, at the heart of the controversy are data that are incomplete, largely contradictory, and seemingly riddled with errors. Critics of the FDA, as well as of the pharmaceutical companies that conducted the clinical trials in question, say the data are "straightforward," despite what critics allege are drug-company efforts to conceal negative data and massage and exploit positive data.

Issue Wouldn't Go Away

Officials at the FDA had thought—and pharmaceutical executives probably had hoped—that the issue of antidepressants and suicide was largely behind them after having studied a potential link in adults who took the medications and having held a controversial public advisory committee meeting in 1991. At that time, the agency determined there was not sufficient evidence to support a solid link. However, anecdotal evidence has continued to surface over the years, often in widely publicized cases of suicide or violent behavior while taking antidepressant medications.

Early last year, however, the issue again erupted, when regulators in both the United Kingdom and the United States were reviewing data that both countries require drug makers to submit on the efficacy and safety of antidepressants in pediatric populations. The initial concerns of the regulators in both countries surrounded data submitted by GlaxoSmithKline (GSK) for its Paxil brand of paroxetine.

Regulators in the United Kingdom, upon analyzing the clinical trials data submitted by GSK, noted what they termed a "signal" of an increased incidence of suicidal thoughts and behaviors in patients taking the active medication in the trials, compared with those patients taking placebo. They asked the company for more data and explanations of what the company thought the data meant. They also shared their concerns with officials at the FDA.

Data Confusing

The FDA's own concurrent analysis of the GSK data raised many more questions than it provided answers, leading the agency to request additional data from GSK and eventually from the makers of eight other similar antidepressant medications.

The agency had reviewed pediatric data on safety and efficacy for those eight other medications over about a three-year period and had noted, according to Thomas Laughren, M.D., FDA's team leader for the psychiatric drug products group, that adverse events—including those suggestive of possible suicidality—had been coded by the trial sponsors of each company somewhat differently. However, suicidality did not emerge as a matter of concern until the agency looked at the data on paroxetine.

It appeared that GSK had lumped different types of adverse events that occurred during the trials, including those suggestive of possible suicidality, into a category labeled "emotional lability." It wasn't clear to the agency exactly what types of events were combined into this category, so the agency asked GSK for clarification of the specific adverse events the company had included in the emotional lability category.

In May 2003 GSK supplied summary data for three clinical trials on paroxetine, first to regulators in the United Kingdom and shortly thereafter to the FDA. The adverse events fell under two categories labeled "possibly suicide related" and "suicide attempts." No completed suicides occurred during these three paroxetine clinical trials (see table on page 76).

In one of the three studies, GSK's study known as "329," six of the 93 patients taking paroxetine had a possibly suicide-related event, compared with only one of the 88 patients taking placebo. That resulted in a risk ratio of 5.9, meaning patients taking paroxetine were nearly six times more likely to have a suicide-related event. In

please see ***SSRIs*** *on page 76*

Criminalization of Mentally Ill People: How Can We Stop It?

BY MARCIA GOIN, M.D.

My presidential initiative has been to take a hard look at the criminalization of people with mental illness. Statistics show that as access to mental health services in the community have decreased, there has been an incremental increase in the number of people with mental illness in the criminal justice system. With this awareness in mind, it was an exciting moment when a group of dedicated experts on the subject joined together last month at APA's central office to brainstorm strategies and future directions for reform (see page 1).

The conference, organized by the APA Corresponding Committee on Jails and Prisons and co-chaired by Dr. Steve Sharfstein and me, focused on these points:

- What do we know?
- What are we doing?
- How can we forge new efforts and plan for the future?

Who was there? Katherine Power, the director of the Center for Mental Health Services (CMHS), and three top center officials; and representatives of the GAINS Center for People With Co-Occurring Disorders in the Justice System, Council of State Governments, Community Services Division of the National Association of Counties, Research Triangle Institute International, Human Services Research Institute, National Association of State Mental Health Program Directors, National Alliance for the Mentally Ill, Bazelon Center for Mental Health Law, and National Mental Health Association. Also participating were the executive director of a state Appropriations Committee and a representative from the Center for Behavioral Health, Justice, and Public Policy.

APA participants included the members of APA's Corresponding Committee on Jails and Prisons; Dr. Howard Goldman, a professor of psychiatry at the University of Maryland School of Medicine who is known for his work on the organization and financing of health care; Dr. Jim Nininger, APA speaker-elect; and Sam Muszynski, director of APA's Office of Healthcare Systems and Financing.

This group was large, the members knowledgeable, and the dialogue throughout the day was lively and informed.

What do we know? We know that large numbers of imprisoned people have current symptoms of serious mental illness. Studies have shown that jail-diversion programs result in positive outcomes for individuals, systems, and communities. The multisite programs studied to determine cost offset varied in their findings. In general, jail diversion results in lower criminal-justice costs and greater treatment costs. The treatment program used in most diversion studies, for both diverted and comparison subjects, usually consists of medication and "counseling." This program—"treatment light"—is less than what is needed for a population that is often struggling with severe mental illness and co-occurring substance abuse. Assertive Community Treatment (ACT) with psychotropic medications and integrated programs for co-occurring substance use disorders is recognized as yielding the best results. Still, even "treatment-light" diversion produced fewer jail days, no increase in arrests, and fewer arrests than the subjects had experienced previously.

David Hughes of the Human Services Research Institute presented a simulation model to predict the cost impact of jail-diversion programs. Designed to make use of evidence-based treatment, good services push people into a better functioning system and in the long run can save money.

You may ask, "Why this focus on the fiscal dimensions when people with mental illness are in the criminal justice system?" Everyone around the table had a strong and abiding interest in making quality treatment available to mentally ill people. However, if we want to improve our chances of receiving the necessary funding in an era of budget shortfalls, evidence that there is a substantial cost offset will result in new programs.

We were fortunate that Katherine Power joined us for most of the day. In her role as director of CMHS, she leads the efforts to implement the report of the President's New Freedom Commission on Mental Health, which was released last year. Among other issues, the report singles out the increased criminalization of mentally ill people as an issue that must be actively addressed. She spoke of the need for state leadership to declare this issue a priority, which must be negotiated with state Medicaid and the justice systems.

Many practical issues were discussed. When people with mental illness are incarcerated, they lose their SSI and Medicaid eligibility. This development increases treatment costs for the states and the counties. People with mental illness are shown to have much longer incarcerations than other inmates. Mothers are separated from children, with a devastating impact on the integrity of family life. Frequently, incarceration occurs at considerable distances from the homes of inmates, incurring expensive and fatiguing travel by family members, who are usually living below the poverty line. The facilities and environment in most jails and prisons aggravate the very illness that has led to bizarre and antisocial behavior. Once people with mental illness have spent time in jail, they are stigmatized in their efforts to receive treatment upon leaving the correctional facility.

We need long-term research programs that include well-designed diversion programs. We must incorporate evidence-based practices, as well as adequate housing and substance abuse programs, in the treatment-planning period. Now there must also be

please see ***From the President*** *on page 77*

Until the Crisis Is Over

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

We are facing a crisis. Now in the third decade of the AIDS pandemic, there is no end in sight. Since 1981 more than 28 million people have died of AIDS. Each day there are 14,000 new infections and 8,200 AIDS-related deaths. In the United States an estimated 850,000 to 950,000 people are living with HIV. Globally, a staggering 40 million people are infected with HIV, including 5 million individuals newly diagnosed in 2003 alone. The devastation caused by AIDS has surpassed even the most dismal predictions of the early 1980s.

No statistics, however alarming, can adequately convey the suffering and human trial these numbers represent. It is this knowledge that lies at the heart of APA's response to the AIDS pandemic through the Office of HIV Psychiatry. We must do all we can to limit new infections and care for those infected by providing psychiatrists with the training, resources, and services needed to best respond to the challenges presented by AIDS and HIV infection—until the crisis is over.

HIV's Assault on the Brain

The involvement of psychiatrists in the diagnosis and treatment of AIDS and HIV infection is essential. Clinical experience and research provide substantial evidence that HIV directly infects the brain soon after initial infection, resulting in central nervous system impairment and neuropsychiatric disorders including HIV-1–associated dementia, minor cognitive-motor disorder, delirium, depression, and psychosis. Current antiretroviral treatments, while improving systemic health, show poor penetration into the brain, increasing the likelihood of cognitive-motor disorders. For those with pre-existing severe mental illness or significant substance abuse experience, the assessment of cognitive capacity is particularly complex.

Describing HIV as "a neuropsychiatric disease with systemic manifestations," Dr. Marshall Forstein, former chair of the APA Commission on AIDS, maintains that "HIV's assault on the brain requires the participation of psychiatrists throughout the course of illness."

APA Responds

Understanding psychiatrists' unique role, APA established the Office of HIV Psychiatry. What began with a project steering committee and a single contract from the federal government has evolved into a mature, successful program. Its mission includes providing HIV-related training and education, developing curricula and clinical resources, ensuring appropriate psychiatric consultation, promoting collaboration with other specialties, ensuring adequate attention to the psychiatric and neuropsychiatric issues, and providing support to a network of psychiatrists and other mental health professionals working in the AIDS arena. Today this mission is achieved through the AIDS Education Project (AEP), APA Committee on AIDS, HIV Steering Committee of the American Psychiatric Institute for Research and Education (APIRE), APA staff, and collaboration with other medical and mental health specialty groups.

Training and Education

Since 1987 the office, through funding from the Center for Mental Health Services (CMHS), has provided training and education to more than 26,000 psychiatrists, psychiatry residents, and mental health professionals. Trainings are based on a comprehensive curriculum whose topics range from central and peripheral nervous-system impairment to comorbidity and psychopharmacology.

Trainings are provided upon request at the local, regional, and national levels and are tailored to meet specific needs and interests of the participants. Training activities vary from one-hour grand-rounds lectures to full-day conferences and resident case discussions. Comprehensive training is also provided at APA's two national conferences, the annual meeting and the Institute for Psychiatric Services.

The office also encourages the use of alternative training-delivery systems. For clinicians who prefer the convenience of self-paced learning, there are two online continuing medical education programs: "HIV and AIDS: An Overview for Psychiatric Physicians" and "Practice Guideline for the Treatment of Patients With HIV/AIDS." This year the office will initiate a distance-learning pilot program in rural and underserved areas. Funded through CMHS and dubbed iSite, the program will feature videoeducation, online discussions, and e-mail consultations.

The office takes pride in working with medical schools and psychiatry residency training programs to incorporate sufficient information and skill development on HIV into their curriculum. To date, the office has provided trainings to more than 1,600 residents at the request of training directors at more than 50 programs. This year, through CMHS funding, the office will also offer a minority medical student elective in HIV psychiatry. The program is designed to increase the number of racial and ethnic minorities entering HIV/AIDS clinical care and substance abuse services. This clinical rotation will provide intense training in HIV mental health, including neuropsychiatry.

Community-Based Training

The office has just entered into a subcontract with Abt Associates to provide neuropsychiatric training to 21 community-based organizations engaged in meeting unmet mental health treatment needs of African-Americans, Hispanics/Latinos, and other racial and ethnic minorities. An APA curriculum developed to train nonphysicians to recognize psychiatric impairment in patients with HIV will provide the foundation for trainings.

Resources and Curriculum

The office offers a variety of resources for those working in this field. Of particular interest is a nine-module curriculum detailing the neuropsychiatric dimensions of HIV infection. This curriculum includes discussion of the following: complications of the central nervous system, mood disorders, anxiety disorders, sleep disorders, pain syndromes, HIV among people with severe and persistent mental illness, substance use disorders, psychotic disorders, and drug interactions and toxicities.

Recognizing the need for psychiatrists to keep pace with current research and information, the office provides myriad resources:

- "Practice Guideline for the Treatment of Patients With HIV/AIDS" is a practical guide on the psychiatric management of patients with HIV/AIDS, representing a synthesis of current scientific knowledge and clinical practice.
- The Web site <www.psych.org/AIDS> offers a searchable resource database and access to guidelines, two CME programs, APA policy statements, fact sheets, and links to curricula and training information.
- Eight one-page summary sheets reflect the content of APA training modules.
- *Network Newsletter* is a quarterly publication that lists funding sources and educational opportunities and provides information on recent research and clinical advances.
- "Neuropsychiatry and AIDS: The Impact of HIV on the Brain and Behavior" is a curriculum for nonmedical providers on the spectrum of cognitive and psychiatric disorders.
- Quick reference guides highlight prevalence, symptoms, diagnosis/differential, and treatment options for anxiety disorders, mood disorders, sleep disorders, pain syndromes, and substance use disorders.
- A number of position statements and guidelines are available on topics ranging from confidentiality and testing to inpatient and outpatient care to the management of neuropsychiatric impairment.

The office, whose annual budget is $278,844, is led by Director Carol Svoboda. She is assisted by Senior Project Manager Diane Pennessi and Training Manager Candice Peggs. Staff work collaboratively with the APA Committee on AIDS and the APIRE HIV Steering Committee. All programs are housed within APIRE and the APA Division of Research. Also essential to the overall structure and success of the office is the participation of a network of more than 500 psychiatrists, including 75 regional trainers committed to providing HIV/AIDS training to health and mental health care professionals across the country. Their time and commitment to resource development, training, and consultation are considered extremely valuable to the goals and objectives of the office.

Looking Ahead

The goals of the Office of HIV Psychiatry have evolved over time to meet the changing needs and interests of the psychiatric community, as well as the demands presented by the epidemic. While much has been accomplished, much remains to be done. APA and the Office of HIV Psychiatry are well positioned and experienced in this arena and will continue to honor a commitment to quality HIV education and services for psychiatrists and quality care for all patients.

Feel free to e-mail your questions, comments, and suggestions to me at medicaldirector@psych.org. ■

N.H. Psychologists Lose Fight For Prescribing Privileges

State legislators in New Hampshire decide that psychologists should not have the privilege of prescribing medications to persons with mental illness and that the issue is not even worth studying.

BY KEN HAUSMAN

Thanks in large part to lobbying and organizing efforts by the New Hampshire Psychiatric Society, lawmakers in the state legislature decided to end for this session the psychologists' quest to gain the right to prescribe psychoactive drugs.

Last March New Hampshire psychologists succeeded in having their legislative allies introduce a bill to grant them prescribing privileges, but it was defeated on the floor by a voice vote.

The most recent attempt to use the legislative route to win prescribing privileges came in the form of a bill that would have mandated a study of the issue. Study bills can be harder to defeat than other types of legislation because many lawmakers are reluctant to sink a proposal that just calls for a controversial issue to be studied. In this case, the content of the study bill (HB 1265) was not much different from last year's bill to grant psychologists prescribing privileges. It called for study instead of enactment.

The switch to a study bill for the most current iteration of the psychologist-prescribing proposal arose after one legislator, John DeJoie, "said he didn't feel that the process [of evaluating a psychologist-prescribing bill] was done correctly last year, so after meeting with psychologists, he decided to introduce a study bill," explained Alex de Nesnera, M.D.

De Nesnera is treasurer of the New Hampshire Psychiatric Society and led the district branch's effort to head off this proposal in the state legislature.

DeJoie said that he hoped that psychologists and psychiatrists could come to some agreement if the proposal was just to study the psychologist-prescribing issue. New Hampshire psychiatrists insisted that with the quality of patient care at stake, the issue was clear cut and not open for negotiation, de Nesnera pointed out. "We also stressed that in 2003 the full House clearly agreed with our view" that allowing psychologists to prescribe was a dangerous idea.

The New Hampshire Psychiatric Society arranged for representatives of the New Hampshire Medical Society, state organizations of family physicians and pediatricians, and the National Alliance for the Mentally Ill to testify against the bill during a committee hearing on January 14.

The committee responsible for reviewing the bill to study the issue voted 15 to 2 to send it to the House floor with a negative recommendation. Several weeks later, the full House voted 266 to 68 to accept the committee's negative recommendation.

De Nesnera expects that a psychologist-prescribing bill will reappear in some form in the next legislative session, and the battle will have to be fought all over again. ■

Association News

Nominations Invited For Research Award

APA invites submissions for its 2005 Award for Research in Psychiatry. First awarded in 1949 as the Hofheimer Prize, this is the most significant award that APA presents for research.

The award recognizes a single distinguished contribution, a body of work, or a lifetime contribution that has had a major impact on the field and/or altered the practice of psychiatry. The award is intended to cover the full spectrum of psychiatric research. The award consists of a $5,000 prize and an honorary plaque to be presented at APA's annual meeting; the winner will be asked to present a lecture in connection with the award.

Candidates must be citizens of the United States or Canada and be nominated by a sponsor; sponsors must be APA members.

Sponsors should submit a letter justifying the nomination in detail and summarizing the nominee's research accomplishments in a specific area or the coherent theme of the research.

Nominees should submit a book, paper, or group of representative and thematically linked books and papers published in English (or accepted for publication); a summary statement emphasizing the principal theme running through the work and its internal cohesiveness and consistency and scientific implications; an up-to-date C.V.; and an up-to-date bibliography.

The award is based on an annual competition, and prior applicants may reapply by submitting a complete set of the required number of applicant materials. The deadline for receipt of submissions is August 27. All entries must be submitted in seven collated sets to Alan F. Schatzberg, M.D., Chair, APA Research Awards Committee, c/o APA Division of Research, 1000 Wilson Boulevard, Arlington, Va. 22209-3901.

More information is available from Harold Goldstein, Ph.D., of APA's Division of Research by phone at (703) 907-8623 or by e-mail at goharold@psych.org. ■

Bush Budget Shows Small Increase for Mental Health

The president's Fiscal 2005 budget request for health and biomedical research reflects his emphasis on priorities other than health and medicine, with a few exceptions. See related column on page 47.

BY CHRISTINE LEHMANN

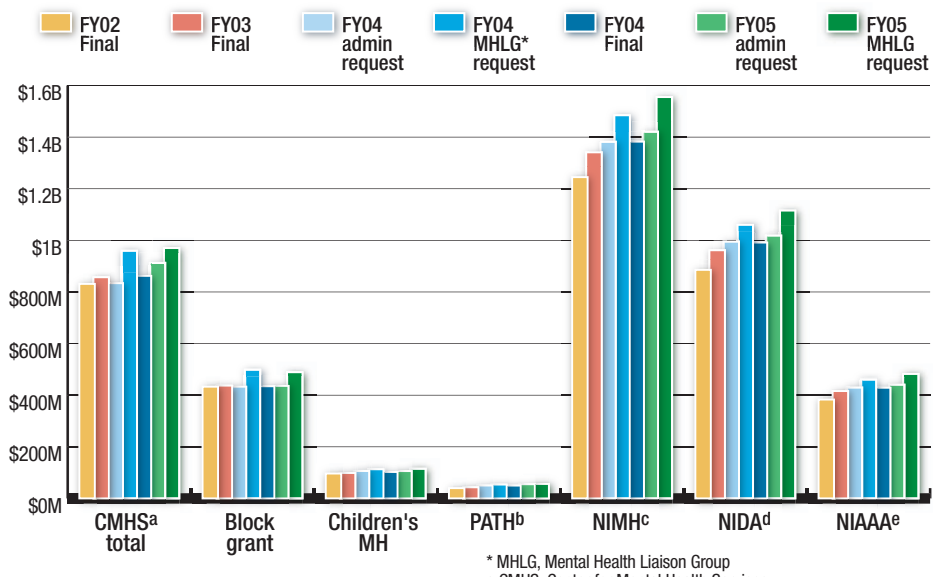
The broad-based Coalition for Health Funding, with more than 200 member organizations including APA, began lobbying Congress last month to increase total federal spending on health services and research in Fiscal 2005 by 12 percent over the current fiscal year's budget.

The coalition sends Congress an annual budget recommendation for the Department of Health and Human Services' (HHS) programs and agencies, including the Centers for Disease Control and Prevention, National Institutes of Health (NIH), and Substance Abuse and Mental Health Services Administration (SAMHSA), according to a coalition mission statement.

The coalition's budget recommendation excludes federal spending on Medicare, military health, and veterans health.

White House Budget for Mental Health Programs

Across the board, administration requests for mental health funding in Fiscal 2005 are up from Fiscal 2004 spending levels, if only by relatively small amounts. However, the administration requests fell short of the recommendations of the Mental Health Liaison Group across all categories.



* MHLG, Mental Health Liaison Group
a CMHS, Center for Mental Health Services
b PATH, Projects for Assistance in Transition from Homelessness
c NIMH, National Institute of Mental Health
d NIDA, National Institute on Drug Abuse
e NIAAA, National Institute on Alcohol Abuse and Alcoholism

Source: Mental Health Liaison Group

In a February letter, the coalition called on President Bush and members of Congress to make the public health system a funding priority.

"Our nation's public health system will not be able to respond adequately to an unprecedented range of threats including infectious and food-borne illnesses, biological and chemical terrorism, and mental disorders and substance abuse without additional resources for the continuum of medical research, prevention, treatment, and training programs," the coalition letter stressed.

Workforce Levels Threatened

Another threat the coalition cited is the shortage of health care professionals and other key personnel.

Lizbet Boroughs, an associate director in APA's Department of Government Relations (DGR), told *Psychiatric News*, "We are concerned about a shortage of not only psychiatrists in the public sector, but also psychiatric nurses and case managers who play essential roles in caring for the mentally ill."

The coalition emphasized that increasing discretionary funding for the public health system by 12 percent over last fiscal year is "critical to improving the health, safety, and security of our nation." This is nearly 10 percentage points more than the president's proposed total increase for HHS of 2.8 percent. However, the bulk of that increase would be for Medicare and Medicaid programs, leaving roughly a 1 percent increase for discretionary funding, which is less than in previous years.

In addition, in his Fiscal 2005 discretionary budget the president proposed spending $4.1 billion on bioterorrism preparedness, according to DGR. Approximately $500 million is deducted for Medicare and Medicaid savings. That leaves a discretionary funding total of $66.75 billion in Fiscal 2005, compared with $67.42 billion in this fiscal year.

Another Small Increase

The NIH is targeted for a proposed 2.7 percent increase over Fiscal 2004 ($764 million), for a total budget of $28.8 billion in the president's budget request.

Bush recommended a 2.7 percent in-

please see ***Budget*** *on page 82*

ADVERTISING

APA, AACAP Advocate for Ban On Executing Juveniles

Increasingly detailed knowledge of brain development gives APA added ammunition in its efforts to convince state lawmakers to ban execution of those who committed crimes as juveniles.

BY KEN HAUSMAN

With the help of scientifically solid testimony from APA and the American Academy of Child and Adolescent Psychiatry, bills to prevent the execution of individuals for crimes committed as juveniles have made progress in three states: On February 19, the New Hampshire Senate voted to raise the minimum age for execution from 17 to 18. A few days later the South Dakota House narrowly passed a bill to bar the execution of those younger than age 18 at the time of a crime. The state Senate had already passed identical legislation, and the bill is expected to become law. And on February 27, a bill to raise the minimum death-penalty age from 16 to 18 passed the Wyoming Senate by wide a margin. As the legislation has already passed the House, it has now been forwarded to the governor for his signature.

What legislators are learning is that adolescents' brains function differently from those of adults and are still developing during the teen years. These brain-development differences affect behavior, judgment, impulse control, and decision-making ability. As a result of these differences between adult and still-maturing brains, even when juveniles commit heinous crimes, the state should not execute them, APA and AACAP contend.

David Fassler, M.D.: "Adolescents actually use their brains differently from adults when reasoning or solving problems."

"Research studies have indicated that adolescence is actually a very active time of growth and development at the physical level of the brain. Specifically, what we see is a rapid increase in the interconnections between the brain cells," explained David Fassler, M.D., in testimony before the New Hampshire legislature on behalf of APA and the American Academy of Child and Adolescent Psychiatry on February 9.

Fassler is a child and adolescent psychiatrist in Burlington, Vt., and an APA trustee-at-large.

His testimony described how imaging studies have shown that "adolescents actually use their brains differently from adults when reasoning or solving problems. For example, they tend to rely more on these instinctual structures, like the amygdala, and less on the more advanced areas, like the frontal lobes, which are associated with more goal-oriented and rational thinking."

What biological evidence now demonstrates, Fassler told the lawmakers, is that in children and adolescents, behavior patterns as well as cognitive and neurological development are still in the formative stages. This means that adolescents "are much more likely to act on impulse, without considering the consequences of their actions, and they are generally more receptive and responsive to intervention and rehabilitation."

"As a society, we have broadly recognized this fact, and as a result we've established separate laws, courts, and programs for juveniles who commit crimes."

Also testifying in favor of barring execution of those who committed crimes as juveniles was psychiatrist Daniel Jackson, M.D., medical director of the Adolescent Service at Arbour Hospital in Boston and an officer of the New England Council of Child Psychiatry. He too cited the increasing sophisticated knowledge that researchers have produced about brain development and urged the legislators not to view adolescents "as just reduced versions of adults."

"Very similar to mentally retarded individuals, adolescents have a varied capacity to understand and process information," he stated. "Their communication skills are limited. Some don't abstract from mistakes to learn from experience. Logic is faulty. They are frequently impulsive and are not yet able to understand the reactions of others.

"The sizable differences that might occur in the degree of frontal-lobe development between ages 17 and 18 further support the necessity," Jackson said, of limiting the possibility of execution to those who committed crimes at age 18 or older.

Fassler concluded his testimony by emphasizing that the legislature was presented with an opportunity "to make a statement that the citizens of New Hampshire will not execute people for crimes committed as adolescents." He stated his hope that before voting on the issue, lawmakers could put aside their emotions on this sensitive topic and "look at the scientific research" showing how different adolescents are from adults.

Last month Fassler offered similar testimony in Wyoming, where he was joined

please see ***Execution*** *on page 83*

More Workers Getting Treatment For Depression, but It's Inadequate

The majority of the costs of depression—62 percent—show up in the workplace in the form of absenteeism and low productivity. Forward-thinking employers are beginning to see the importance of high-quality mental health care.

BY MARK MORAN

The economic burden of depression remained relatively stable in the 1990s, despite a dramatic increase in the proportion of people with depression being treated.

A 10-year study on the economic burden of depression appearing in the January *Journal of Clinical Psychiatry* found that the annual cost of depression (including major depression, bipolar disorder, and dysthymia) rose just 7 percent in inflation-adjusted dollars between 1990 and 2000, despite a more than 50 percent increase in the number of people being treated for the condition.

Of the $83.1 billion spent in 2000 on the treatment of depression and related expenses, $26.1 billion (31 percent) were direct medical costs, $5.4 billion (7 percent) were suicide-related mortality costs, and $51.5 billion (62 percent) were workplace costs.

But study author Ronald Kessler, Ph.D., believes that behind the good news about stable costs and increasing treatment numbers is a less-encouraging story of substandard care.

"It's striking that we have known for a couple of years now that the number of people in treatment for depression has gone up, and you would expect that the cost of treatment would have skyrocketed," Kessler, an epidemiologist at Harvard Medical School, told *Psychiatric News*. "But once you get inside the numbers, the news is not so good. Many more people are getting pharmacotherapy from a primary care physician, but they may not be getting it at the adequate dose or for the appropriate amount of time."

Kessler, a professor of health care policy at Harvard Medical School, said he believes much of the increase in numbers of people being treated is driven by patients who seek out medication from a primary care doctor, but who are very liable to stop taking medication as soon as they begin to feel better.

"These people are much more likely to take a pill for 15 days or 30 days and then drop out of treatment when they feel a little bit better," Kessler said. "So, the downside of the increasing numbers of people being treated and the cost of staying stable is that we are spending a lot of dollars on people who are not getting adequate treatmentHe added that he believes better coordination of care between primary care and psychiatrists and mental health specialists is the key to cost-effective, high-quality care."

Paul Greenberg, M.A., M.B.A., who co-wrote the report with Kessler, told *Psychiatric News* the study found much of the treatment of depression had shifted from inpatient to outpatient—specifically, primary care—settings.

"This is not going to come as a surprise to psychiatrists," he said. "In 1990 about two-thirds of direct medical costs were hospital days. By 2000 inpatient care accounted for only a third of direct medical costs."

Greenberg is managing principal at Analysis Group, an economic, financial, and strategy consulting firm with offices throughout the United States and Canada.

Kessler and Greenberg used a human capital approach—an analytical tool used to measure an individual's productive capacity—to develop prevalence-based estimates of direct costs of depression, mortality costs arising from depression-related suicides, and costs associated with depression in the workplace.

Among the study's most striking findings is the persistence of the workplace as the site where depression exacts its highest economic toll.

"The majority of costs still show up in the workplace in the form of reduced capacity to work," Greenberg told *Psychiatric News*. "These are people who show up for work but can't work at their usual level of performance, as well as people who cannot show up for work at all. So absenteeism and 'presenteeism' continue to be economic factors in the cost of depression.

"Clearly, the activities of daily living for a depressed person are dramatically adversely affected," Greenberg said.

And he noted also an important implication of the study findings: as economic conditions improve, more people are employed and covered by health insurance and therefore more likely to be treated when they are depressed. Conversely, in a sluggish economy fewer people will be employed and able to access care.

Kessler echoed the importance of the cost of depression in the workplace, citing it as an area of immense opportunity.

"There is an entire burgeoning area of literature that looks at the impact of medical conditions on role performance," Kessler said. "Depression is one of the most costly conditions in the workplace, and the majority of dollars for health care comes from employers. They are very interested in knowing what they are getting for their dollar. Where once mental health was likely to be the first thing cut, today a lot of forward thinking employers are seeing the value of high-quality mental health care." ■

IOM Report Provides Road Map To Medical Workforce Diversity

Efforts to recruit and retain minorities in medicine have been marginally successful, prompting new recommendations from the Institute of Medicine on increasing diversity in the health care workforce.

BY CHRISTINE LEHMANN

There is a large gap between the rapidly growing minority populations in the United States and their representation among health professionals, in particular registered nurses (RNs), psychologists, and physicians, according to an Institute of Medicine (IOM) report titled "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce."

The IOM is a component of the National Academy of Sciences, an independent organization chartered by Congress to advise the government on scientific matters.

According to the report, Latinos constitute 12 percent of the general population, but make up only 2 percent of RNs, 3.4 percent of psychologists, and 3.5 percent of physicians. And, while 1 in 8 Americans is African American, fewer than 1 in 20 physicians or dentists is African American.

While Asians and Pacific Islanders make up 20 percent of medical graduates, which exceeds their representation in the general population, in some communities Asians still have problems getting access to mental health care and medical and dental attention, according to the report.

Why is diversity among health professionals important? The report noted that minorities are more likely to serve in minority and medically underserved communities, improving minority access to health care. Diversity also contributes to "greater patient choice and satisfaction, better communication between health professional and patient, and better educational experiences for all students while in training."

Organizations representing the health professions have made an effort to recruit more minorities, but they have had limited success, said the report.

For example, only 7 percent of all psychiatry residents in the United States in academic year 2002-03 were African American and 7 percent were Latino, compared with 55 percent for whites, according to the "Census of Psychiatry Residents 2002-03" by APA's Office of Graduate and Undergraduate Education.

The IOM report urges government officials and educators to take steps to recruit more African Americans, Latinos, and other minorities to the medical profession. The report offered these suggestions on how to accomplish that goal:

- Health education institutions should include an applicant's race, ethnicity, and language skills in admission decisions and have minorities represented on admission committees.
- Congress should increase funding for programs to increase diversity in the health care workforce.
- Health profession accreditation groups should encourage schools to recruit minorities, stress the value of minorities in health care, and include minorities on their boards.

"I commend the IOM report for linking together increasing diversity in the health care workforce with cultural competence and eliminating health care disparities among minorities," said Francis Lu, M.D., chair of APA's Council on Minority Mental Health and Health Disparities, in an interview with *Psychiatric News*. "These three areas are interrelated and should be addressed together when discussing reforms."

The council will address the IOM report when it meets at APA's annual meeting in May, said Lu, who is also a professor of clinical psychiatry at the University of California, San Francisco.

Altha Stewart, M.D., chair of APA's Council on Social Issues and Public Psychiatry and co-chair of APA's Steering Committee to Reduce Disparities in Access to Psychiatric Care, told *Psychiatric News*, "I am pleased that the IOM report is focusing attention on the need for more diversity in the health care workforce, which relates to the 2002 IOM report on minorities and disparities in health care."

Stewart continued, "Hopefully, the funding and resources will be made available to create more opportunities for minorities to practice and teach in underserved areas."

Stewart, who is also president of the American Psychiatric Foundation, noted that last year the foundation created the Minority Mental Health Awards *(Psychiatric News*, June 20, 2003). In addition, the foundation recently initiated a small grant program to encourage APA's district branches to attract more minority medical students into psychiatry.

The first grant was awarded last year to the Florida Psychiatric Society to sponsor medical students to attend the society's scientific meetings. More grants are available to be distributed this year, according to foundation staff.

"APA has a long history of supporting minorities. With this funding, it is hoped that we can continue that tradition, enhance diversity, and reduce health care disparities," Stewart said.

"In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce" is posted online at <www.iom.edu/report.asp?id=18287>. ■

Experts Describe When Analysis Ready to End

One reason that patients decide to terminate analysis may because they, like all people, prefer narratives with a beginning, middle, and end.

BY JOAN AREHART-TREICHEL

The public often has the impression that once a relationship between a psychoanalyst and a patient gets under way, it will go on indefinitely. After all, it's common knowledge that filmmaker Woody Allen spent years in analysis.

In truth, though, most analyses do end, several psychoanalysts said at the meeting of the American Psychoanalytic Association in New York City in January.

The purpose of analysis, as of other psychotherapies, is to relieve suffering and symptoms, Kerry Sulkowicz, M.D., a New York City psychoanalyst, explained at a session for the press. But with analysis, he explained, a therapist works hard to get at the root causes of a disorder or disorders, and analysis should bring about changes in some fundamental aspects of the patient's personality. As a result, a patient may need to stay in analysis for at least five years for such goals to be achieved. Nonetheless, Sulkowicz pointed out, analysts do want analysis to end, and termination usually comes through mutual agreement between the analyst and patient, although most often it is the patient who initiates termination.

Patients want to end analysis or may be spurred in that direction when they become aware that analysis has brought them greater psychological health—for instance, a reduction in inner conflicts and more freedom with their emotions and relatedness to others, suggested Joseph Caston, M.D., a San Francisco analyst, in a paper presented at the meeting. Another reason why patients want to bring analysis to a close, Caston proposed, is "the human pull to construct narrative structures—such as beginnings and especially endings. . . . Children become able to recognize beginnings, middles, and endings by at least age 5, and after that it is a part of us forever."

In fact, undertaking analysis is not unlike writing a poem, Caston ventured—"both must begin, both have one point or many, and both end with a sense of significance."

But bidding adieu to one's analyst can also mean *auf wiedersehen* ("see you again" in German), Sandra Walker, M.D., a Seattle psychoanalyst, pointed out at the press briefing. In other words: Sometimes patients return to their analysts for additional treatment or a "tune-up". ■

Is the Couch Just A Couch?

Although *la chaise longue* that Sigmund Freud used with his patients is still alive and well, couches are no longer considered *la pièce de résistance* in analysis that they used to be.

BY JOAN AREHART-TREICHEL

Whatever happened to Freud's famous couch—the one on which his patients used to recline and "free-associate"? It is alive and well in 20 Maresfield Gardens, London, England. That is the house where Freud and his family lived after they fled Austria and the Nazis in 1938 and is now the Freud Museum.

But at the dawn of the 21st century, couches in general are no longer the centerpiece of psychoanalysis that they used to be, Kerry Sulkowicz, M.D., a New York psychoanalyst, reported at a press briefing at the American Psychoanalytic Association meeting in New York in January.

According to prevailing psychoanalytic philosophy, he explained, the analytic perspective and the analytic process—not the couch—are the most important tools in analysis. The couch, like the frequency of analytic sessions, is considered a device that can foster a greater depth of exploration of the patient's mind. Hence an analyst today will sometimes use it and sometimes not. Of course, patients have a choice, and sometimes whether a patient feels like reclining during a session becomes a takeoff point for discussion.

Still another couch-related trend, Sulkowicz added, is to use the couch at times for dynamic psychotherapy, since analysts these days spend most of their time doing dynamic psychotherapy, not traditional analysis.

"But is the couch left in the analyst's office when it is not in use?," a reporter asked. "Or is it folded up or stowed somewhere else until it is again needed?"

"It stays in place," Sulkowicz replied with a chuckle. "We do not use a Murphy-bed type of couch." ■

Sorel Honored

President Ion Iliescu of Romania recently awarded Eliot Sorel, M.D., of Washington, D.C., with the Star of Romania Order of Commander in a formal ceremony at the Cotroceni Presidential Palace in Bucharest in recognition of Sorel's contributions to Romania, Romanian culture, science, and medicine. Sorel is a member of APA's Council on Global Psychiatry. ■

Analysts Reinterpret Role Of Religion, Spirituality

Although psychoanalysts once took a dim view of spirituality and religion, deeming them infantile and psychologically unhealthy, some analysts are now studying the topics and discussing them with patients.

BY JOAN AREHART-TREICHEL

Half a century ago, the subjects of spirituality and religion were anathema in the realm of psychoanalysis, Mortimer Ostow, M.D., a psychoanalyst from the Bronx, N.Y., said at the American Psychoanalytic Association meeting in New York City in January.

For instance, when Ostow studied at the New York Psychoanalytic Institute during the 1940s, no one was supposed to talk about spirituality and religion. And when he taught at the Jewish Theological Seminary during the 1950s, the psychoanalytic community took a dim view of that activity. "It has been the practice of analysis to ignore religious associations," he said. This is not good, he asserted.

Ostow and other analysts tackled the subjects of spirituality and religion at the meeting. It is new in the history of analysis to be talking about such things, admitted Paula Hamm, M.A., a McLean, Va., analyst.

Spirituality is a "reaching out" to a natural or religious source, Ostow said; one feels in touch with a transcendent object. Spirituality is a regression to an early phase of childhood development. It is like an infant yearning for its mother.

Spirituality and religion are not the same, Ostow continued. Spirituality exists prior to religion in a person. The spiritual experience is affect; religion is cult, ritual, myth, morality. "Spirituality has nothing to do with morality," he said.

Prayer, at least Jewish prayer, is essentially a mantra—a talking to God, Ostow explained. It is a desire to speak out and to be heard.

In fact, "speaking in tongues"—talking in languages one does not understand—is also motivated by a desire to speak out and be heard, Ostow said. It is like a babbling child reaching out to its parents and wanting them to understand, although they do not yet. Speaking in tongues, he added, brings people together via a diffusion of their ego boundaries.

But is that the only impact that speaking in tongues has on people? Tiina Allik, Ph.D., a psychoanalyst and a professor of religious studies at Loyola University in New Orleans, is not so sure. When Allik was a teen, she and her family joined a group of Estonian Baptists in Toronto for a religious service. Some of the people started praying in tongues, she said, and "the effect was startling." And then, she said, her mother fell backward, moaned, and spoke in a deep voice that she could not understand.

"I became aware of an energy that pervaded the room. . .that flowed through my body," Allik reported. This experience, she said, made her wonder whether "the electrical charge" she felt was a projection of her own feelings or something external combining with something inside of her. In any event, speaking in tongues appears to involve an altered state of consciousness not only in the speaker but also in the listener.

Mystical experiences, too, "are typically altered states of consciousness," Leon Wurmser, M.D., a Towson, Md., psychoanalyst reported. "Such trancelike states," he explained, "necessarily entail large-scale denial. . . . Although one hears and sees, the content of what is seen and heard is being treated so as if one had not heard or seen it. . . . It is thus a matter of making its emotional, affective meaning invalid. . . . "

Mystical experiences, however, are not the same as psychotic experiences, Ostow stressed. For instance, whereas the psychotic hallucination is enduring, the mystical vision is transient. And in most mystical experiences there is a revelation, whereas if psychotic hallucinations contain a revelation, which is rare, it will be a pseudo-revelation.

"Mysticism," Wurmser continued, "tries to find access to the mysteries of 'being' with the help of a world of images, feelings, thoughts, and wishes of inwardness. It may come as ecstatically exalted erotic love without physical sexuality, rather known from Christian and Muslim mysticism. . . . In contrast certainly to Christianity, Jewish mysticism (as Judaism in general) values sexuality in its physical form very highly. . . ."

Some analysts attending the psychoanalytic association meeting also broached the subject of whether analysts should address patients' spiritual and religious needs.

Hamm reported that she has a number of patients who want to talk about spirituality or religion. "The way I handle it is, I ask questions," she explained. "I'm very curious about it." Another analyst reported that discussing religion with a patient helped the patient seek forgiveness.

Ostow said that he does not introduce the subjects of spirituality and religion into analytic sessions, but if patients bring them up, he discusses such subjects with them.

In fact, Ostow attested, discussing spirituality and religion with patients sometimes furthers the analytic process. For example, he once had a patient describe what appeared to be a spiritual experience. He confronted the patient about it, and then the patient started to change for the better—it was a turning point in his analysis. ■

Psychiatrists Outside of Managed Care Value Autonomy in Treatment Decisions

Psychiatrists who have "opted out" say their choice is in part a protest against managed care. But it is also a matter of exercising the physician's autonomy to practice as he or she believes is best.

BY MARK MORAN

Psychiatrist Robert Emmons, M.D., is just saying "No." To managed care, that is. The Burlington, Vt., psychiatrist is one of a surprising number of physicians around the country who are finding that they can survive outside the enormous system of third-party reimbursement and insurance company oversight by which Americans receive health care.

Lisa Mellman, M.D.: "One may make a decision to opt out or in at one point in a career and make another decision at another point."

It is a choice that is not without cost: it means foregoing the security of a guaranteed patient load that comes from contracting through health plans with private employers and state and local government agencies. But it reaps in return for Emmons the right to practice the way he wants, without the interference of a third party.

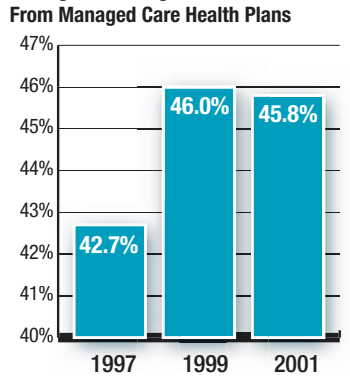
He does not accept payment from private managed care companies and does not participate in provider panels. He benefits, in a way, from the growing number of health plans that provide reimbursement for out-of-network physicians, but even in those cases he deals only with the patient, not the health plan. He also does not accept payment from Medicare or Medicaid.

"The way I describe it, I have a relationship with my patient, who pays me at the time of the service," Emmons said. "If the patient has health insurance, that is the property of the patient, and he or she can be reimbursed. But if I have the serious responsibility of caring for a person, I want to have complete clinical authority to make decisions unhindered by a third party."

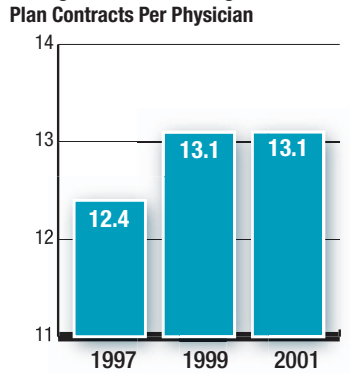
Levels of Participation

Of those physicians who had managed care contracts in 2001, nearly half of their practice revenue (45.8%) came from the 13.1 managed care plan contracts they'd signed, on average.

Average Percentage of Practice Revenue From Managed Care Health Plans



Average Number of Managed Care Plan Contracts Per Physician



Source: Center for Studying Health System Change

William Callahan, M.D., an "independent" psychiatrist, offers a free group discussion for individuals who have a family member with severe mental illness.

Independent Practice, Not Opting Out

According to the 2002 National Survey of Psychiatric Patients conducted by the American Psychiatric Institute for Research and Education's (APIRE) Practice Research Network (PRN), a surprising 52 percent of psychiatrists are not on any managed care panels. Approximately 1,200 psychiatrists, randomly drawn from the American Medical Association master file, responded to the survey.

The PRN is expected to have more detailed information about patient access to psychiatric care across various health plans.

"Psychiatrists in managed care work with low fees, administrative hassles, and late claim payments," said Lawrence Lurie, M.D., chair of APA's Committee on Managed Care. "The ones who opt out say it takes up too much of their time for too little pay, and they want to opt out even if it means fewer patients. They say they can control their own life and can provide better care."

Psychiatrists who spoke with *Psychiatric News* said their choice is in part a protest against a system of financing that they believe is bound to be detrimental to patient care. But it is also a more basic matter of exercising the physician's autonomy to use a medical license to practice as he or she pleases.

"Physicians tend to be a fairly independent lot, and they don't like to feel controlled," said Lisa Mellman, M.D., chair of APA's Committee on Psychotherapy by Psychiatrists, who has also chosen to opt out.

She said that many senior psychiatrists in New York City have done so and that the phenomenon is liable to be widespread in areas where there is high penetration of managed care and where the level of stigma surrounding mental health care is not so great.

Emmons said that even the phrase "opting out"—implying that one is quitting the only game in town—cedes to managed care the right to define the rules of the game; he prefers the term "independent practice."

He confirmed locally what the PRN survey appears to show nationally. "By my count, we have 30 psychiatrists in private practice in Burlington, and I know of 10 who are independent."

No Longer the 'HMO State'?

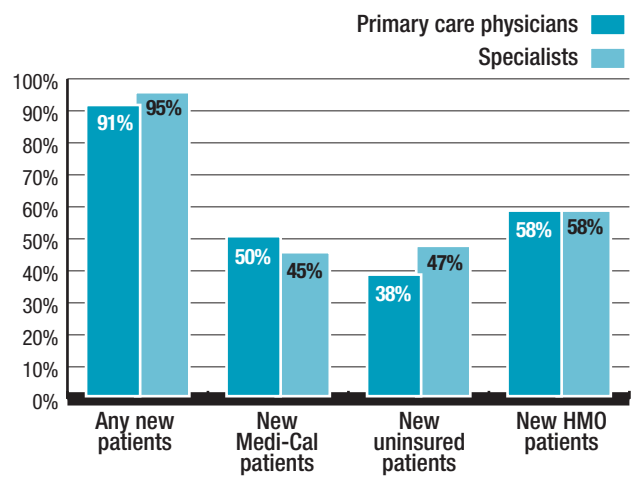
That independent practice is by no means an isolated phenomenon, nor one that is confined to psychiatrists, is underscored by data from a December 2002 report by the Center for the Health Professions at the University of California, San Francisco, which found that only 58 percent of all physicians in California were accepting new patients with HMO coverage.

The figures are noteworthy in a state that has been called the "bellweather" of managed care. The report also found that the percentage of specialists with HMO patients fell from 77 percent to 62 percent between 1998 and 2001, and that the rate of physician participation in HMO plans is approaching the historically low rate of

please see ***Managed Care*** *on page 78*

Are You Taking New Patients?

Most physicians in California are still taking some new managed care patients, but far fewer are taking HMO or Medi-Cal (California's Medicaid) patients. Data are from 2001.



Source: "California Physicians 2002: Practice and Perceptions," California Workforce Initiative

The Dilemma of Opting Out—or In

Do physicians have a professional responsibility to participate in the managed health care plans through which the vast majority of Americans receive medical care? By choosing not to participate in managed care panels, a physician is by definition limiting his or her services to only those who can pay.

"A lot of doctors who have stayed in managed care have done so because as physicians they feel they have an obligation to serve a wide range of patients," said Lawrence Lurie, M.D., chair of APA's Committee on Managed Care.

Lurie, who is now retired from practice, said that he saw in his own practice how managed care had expanded access to people who had not previously been treated in the mental health system.

A December 2002 report by the Center for the Health Professions on practice patterns in California found that "the problem of lack of availability of physicians in many regions of the state is largely due to physicians not accepting patients with certain types of health insurance (or without health insurance altogether) rather than due to an absolute shortage of physicians. . . ."

But Lurie and others interviewed by *Psychiatric News* said that the math is not so simple, and that the finger can be pointed in the opposite direction—at the system itself. "If an insurance plan sets up a system that doesn't provide adequate reimbursement," said Burlington, Vt., psychiatrist Robert Emmons, M.D., "it's the insurance plan that is limiting access."

Managed care, especially the sort that provides financial incentives for meeting capitated budgets, has its own professional conundrums.

"I am very concerned about the conflict of interest that is inherent in managed care," Emmons said. "The work is hard enough that I don't like to add more complications. Of course, it's not a perfect world, but if there is a financial conflict of interest that can be avoided, I would prefer to do so." Emmons said that he treats patients with a wide range of incomes and circumstances, including some patients eligible for Medicaid and Medicare. But he acknowledges his practice is not for everyone. He practices psychoanalytically oriented psychotherapy and noted that patients with complex serious mental illness are liable to be better off in a clinic setting.

Ed O'Neil, Ph.D., director of the Center for Health Professions, which published the report on California practice patterns, added that the autonomy of the physician is an accepted tradition.

"Medicine has historically acted this way and made individual adjustments in fees as well as providing charity care for free," he said. "The broader issue of health care finance for everyone is something that I think all doctors should work on, but if the financing system fails, it is not the ethical fault of physicians. They should not be held responsible for the financing system."

Lisa Mellman, M.D., said physicians choosing to practice independently have options for providing care to those who cannot afford to pay under a fee-for-service model.

"Everyone deals with it in his or her own way," she said. "A psychiatrist may work part time in a clinic system and feel comfortable that he or she is providing care for the underserved and those who cannot pay."

She added, "There are better and worse managed care systems, and each individual physician has to make a decision at each juncture in his or her career and development. One may make a decision to opt out or in at one point in a career and make another decision at another point."

Lurie believes that opting out is a form of protest that may register change in the system. "Some of the companies are realizing that they have to deliver a better product and to be more psychiatrist friendly," he said.

Telemedicine Advances Could Expand Psychiatric Care

Most psychiatrists agree that when possible, face-to-face assessment and treatment are optimal. But they say that telepsychiatry is a close-enough approximation to make it more than acceptable when the alternative is no access to psychiatric services.

BY MARK MORAN

The answer to the lack of access to psychiatric services in many parts of the country is simple: psychiatrists need to be in more than one place at one time.

And today "telepsychiatry"—the use of technology to facilitate psychiatric treatment and education across distances—could turn what once seemed like a whimsical fantasy into reality.

Telemedicine, of which telepsychiatry is a specialty, refers generally to the use of any kind of technology to facilitate the practice of medicine across distances—phone, fax, electronic record keeping, e-mail therapies, and use of the Internet to post educational material for patients. But the model that has the most far-reaching and transformative potential is the use of videoteleconferencing (VTC), allowing physicians and patients to see and talk to each other in remote sites using a video camera and television screen.

Experts say it promises to expand access to psychiatric care, especially in traditionally underserved areas and practice settings.

"I think it is the wave of the future," said former APA president Rodrigo Muñoz, M.D. "Telemedicine makes it possible to interview someone who is miles away from you. It is a response to the maldistribution of physicians and psychiatrists, and it is an opportunity to explore the limits of the power of technology."

Obstacles to telepsychiatry include resistance to technology on the part of both physicians and patients, limited reimbursement for telemedicine, and licensing issues around teleconferencing across state lines. Moreover, some psychiatrists acknowledge that elements of a face-to-face communication can be lost when the patient and psychiatrist interact via a television screen.

But there is no doubt that the use of VTC to expand psychiatric practice and education across distances is growing. Large telepsychiatry programs have been established in Kansas, Oklahoma, Arizona, Montana, and North Carolina, among other states. Internationally, Australia, Sweden, Norway, and Canada have been leaders in the field because of their dispersed populations.

"I would say telepsychiatry is in its adolescence," said Col. Stephen J. Cozza, M.C., chief of the department of psychiatry at Walter Reed Army Medical Center in Washington, D.C. He is also vice chair of the Mental Telehealth Special Interest Group of the American Telemedicine Association (ATA).

"Many centers have been set up in the U.S. and around the world, and they all vary in their level of maturity," Cozza told *Psychiatric News*. "Most have been set up to meet the needs of rural populations in remote sites that have no access to services in their community."

Cozza said it is an alternative to what he called the substandard care that might occur when lesser-trained personnel provide mental health care. "When you bring in telepsychiatry," he said, "you can get expert opinion immediately that allows for psychiatry to continue to set the standard of care, even in remote sites."

States Require Reimbursement For Telemedicine

Five states—California, Louisiana, Texas, Oklahoma, and Kentucky—have passed legislation mandating private insurance coverage of medical services provided by telemedicine, according to the American Telemedicine Association.

The Louisiana law (SB 773, approved in 1995) states that a health care provider participating at the originating terminus of a telemedicine transmission shall be reimbursed at a rate of not less than 75 percent of the amount of reimbursement for an office visit. The bill prohibits provisions in health and accident policies that discriminate against payments for telemedicine.

In California, the law (SB 1665, approved in 1996) prohibits insurers from requiring face-to-face contact between a clinician and patient for services appropriately provided through telemedicine, subject to the terms of the contract.

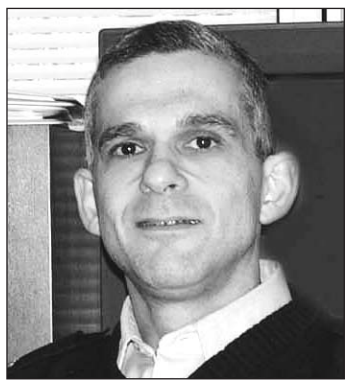
The Oklahoma law (SB 48, 1997) provides that health care plans cannot deny coverage for services provided through audio, video, or data communications. This would allow compensation for patient consultations and diagnoses and the transfer of medical information through telecommunication technology. The law excludes telephone and fax communications from the term "telemedicine."

Kentucky prohibits Medicaid and private insurers from excluding coverage for services provided through telemedicine. Likewise, Texas prohibits private plans from excluding coverage for telemedicine services; those services may be subject to deductible and copayment requirements not to exceed those for face-to-face services.

More information is posted online at <www.amdtelemedicine.com/private_payer/state_legislation.cfm>.

Psychiatrists familiar with telepsychiatry said that patients respond well to the use of video technology.

"I have been surprised at how effective telepsychiatry is with a wide range of patients," says Christopher R. Thomas, M.D., a professor of psychiatry in the department of psychiatry and behavioral sciences at the University of Texas Medical Branch (UTMB) in Galveston.



Col. Stephen J. Cozza, M.C.: "Physically sitting in the same room with a patient is not always necessary."

Success in Women's Shelter

The telepsychiatry program at UTMB has put forward several grants to extend psychiatric care to underserved populations in schools and—in what is perhaps the most novel use to date of telepsychiatry—in a shelter for women.

"I was initially concerned about the patients in this project that serves a women's shelter, as most would be in acute distress with severe symptoms and possibly suicidal," Thomas said. "These are women who have been severely abused in the past by men, and I was concerned about whether they would be able to form a therapeutic relationship with me. To my knowledge, this is the first time telepsychiatry has been attempted with such a population."

Thomas said that the results have been impressive. He believes that the teleconference actually offers the women some degree of control and safety they might not feel in a face-to-face interview with a man.

"Many of the women seen in our program have severe anxiety disorders and agoraphobia and have never received mental health services before," he said. "The teleconference link appears to afford a more comfortable and tolerable contact for them."

Thomas, who is also a child psychiatrist, said his interest in telepsychiatry was sparked initially by the severe shortage of child specialists across the country. At UTMB, Thomas and colleagues have a developed a multi-school district telepsychiatry program allowing consultation with school teachers about students experiencing behavioral problems.

He also works with some individual children by teleconference, the novelty of which makes for an easy, fun way to engage with youngsters. "I have one young patient with PTSD who likes to spend time controlling the camera at my end and looking around at my office," he said.

Lost in Translation?

But does something get lost in the translation from face-to-face encounter to teleconference?

Most psychiatrists agree that when possible, face-to-face assessment and treatment are optimal. But they say that telepsychiatry is a close-enough approximation to make it more than acceptable when the alternative is no access to psychiatric services.

"I don't claim that it is optimal or preferable," said Muñoz. "But the difference is not between good and better, but between good and nothing at all."

Cozza said that research has demonstrated the equivalence between VTC and face-to-face interviews in terms of patient satisfaction and diagnostic accuracy.

"I do think there are some differences between the modalities, but I don't think they are such that VTC cannot provide a quality clinical interaction," he said. "When given the option, I prefer face-to-face [sessions] over VTC. But there are so many areas in this country that don't have the luxury of easy access. In those cases I think we have a professional responsibility to expand this modality to increase care to the underserved."

Using videoteleconferencing can be professionally satisfying as well, Cozza said. "It is tremendously rewarding when you realize that you helped a person or family that has needlessly suffered for a long time without getting care," he said. "It has made me think a lot about my traditional practice. What is important about what we do with patients? What is essential? There are many things that are, but I have come to believe that physically sitting in the same room with a patient is not always necessary."

Barriers Rife

Still, a number of barriers and obstacles exist to making telepsychiatry a standard practice. One prominent issue is licensing, and physicians who engage in telemedicine across state lines typically need to pick up additional state licensure.

Another issue is that the technology may not yet be affordable for many hospitals, academic medical centers, or physician practices. VTC typically requires a camera, monitor, communication lines, and CODEX; CODEX collects information from incoming telephone lines, interprets it, and displays it on the monitor.

Rodrigo Muñoz, M.D.: "Telemedicine is a response to the maldistribution of physicians and psychiatrists."

"Technology costs money," said Robert Hsuing, M.D., chair of the Mental Telehealth Special Interest Group of the ATA. "It also can mean savings, on transportation, for example. But it's no simple matter to transfer those savings to technology."

Costs for equipment range from $5,000

please see ***Telepsychiatry*** *on page 16*

professional news

Internet Show Links Caregivers, Child Experts

Adults living and working with children who have developmental or emotional disorders can now benefit from expertise offered via a weekly Internet show.

BY EVE BENDER

A new show that blends the best aspects of talk radio and the Internet is educating the public about the needs of children with developmental disorders and serious emotional disturbances.

"Infants, Children, and Families" is a weekly Web-based program hosted by Stanley Greenspan, M.D., a clinical professor of psychiatry and pediatrics at George Washington University School of Medicine. Among the books he has written or co-written are *The Challenging Child* and *The Child With Special Needs: Encouraging Intellectual and Emotional Growth*. Greenspan is chair of the Interdisciplinary Council on Developmental and Learning Disorders, which he established to improve care for children with special needs.

On Thursdays from 10:30 a.m. to 11:30 a.m. Eastern Time, Greenspan discusses a topic related to the development of children with communication, learning, attention, speech, or impulse control disorders. He also discusses each topic in relation to children who develop normally.

Although the show is held in an interactive, talk-radio format in which Greenspan takes questions from audience members who call in, the audience doesn't tune in to a radio station. Instead, they are at their computers at the Web site <www.floortime.org>, which uses streaming video and audio. Thus, the audience can also submit questions via e-mail.

"The great thing about the Web is that there are no breaks, no advertisements, and if you miss the live show, it's archived, so you can access it anytime," Greenspan told *Psychiatric News*.

His approach to children with developmental disorders is based on the Developmental, Individual-Difference, Relationship-Based/Floortime Model (DIR), which he developed with colleagues such as Serena Wieder, Ph.D., in the 1990s.

Greenspan designed the DIR model to help children master a number of fundamental emotional and intellectual skills through play, problem solving, and language, for instance, and the approach is customized to individual differences in auditory and visual processing, as well as motor planning and sequencing, according to Greenspan.

The first show, "We Can Do Better," debuted in February and dealt with revising educational goals for children. In later shows, Greenspan discussed topics such as helping parents and caregivers better understand the different ways in which their children process the world and how to create learning opportunities at home and school.

Future shows will focus on topics such as helping children with developmental and emotional problems learn how to regulate their moods and behavior, learn empathy, and acquire high levels of reflective thinking.

"These are skills that were once thought to be unattainable for children with developmental challenges," he noted.

Thus far, according to Greenspan, he has gotten questions from people all over the United States, including parents of autistic children who, for example, are concerned because their children will not make eye contact or otherwise engage people around them.

In such cases, he said, it is best to get involved in the child's natural interests, because "that's where their emotional investment lies."

"Infants, Children, and Families" can be accessed online at <www.floortime.org>. ■

Telepsychiatry

continued from page 15

to $7,000. The cost of ISDN BRI (Integrated Services Digital Network Basic Rate Interface)—which translates voice, data, and video communications into a digital signal transmitted over a single multipurpose line—is approximately $88 a month. Additional costs for actual connection time vary depending upon the local/long distance calling plans.

Reimbursement for services provided through telemedicine also remains limited. Medicare reimburses for telemedicine, Hsuing said, as do some private payers. But many do not. Five states have passed laws mandating private insurance coverage of services provided through telemedicine (see box on page 14).

Finally, there is the age-old fear of the new. As Hsuing said, "Generally, people are resistant to change, and psychiatrists are people."

Cozza said that, as with any new idea, there must be a champion to push it forward. "There needs to be someone who takes the initiative to spearhead the effort," he said. "Once the ball gets rolling, though, my experience is that these programs prove themselves in terms of efficacy and helpfulness."

Whatever the barriers and obstacles, there is within the field of telepsychiatry a clear sense of the inevitability of technological progress—and an equally strong urgency about using that technology to meet the problems around access to psychiatric care.

Phyllis Harrison-Ross, M.D., founder and managing partner of Black Psychiatrists of Greater New York and Associates, told *Psychiatric News* that her organization is strongly advocating the use of telepsychiatry to gain access to services for people in prisons and jails, homebound seniors, and others. The group's Web site at <www.BPGNY.com> carries several articles of interest regarding telepsychiatry, including streaming videos featuring David Satcher, M.D., former U.S. surgeon general, among others.

APA's 2004 annual meeting in New York in May will feature the course "Enhancing Health Care Delivery: Let Telepsychiatry Help."

The ATA published a "white paper" on reimbursement for telemedicine that is posted online at <www.americantelemed.org/news/Reiumbursement%20White%20paperfinal.pdf>. Other information is posted at <www.americantelemed.org>. ■

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Psychiatrist Helps Heal Centuries-Old Wounds

Relationships between Protestants and Catholics in Northern Ireland may continue to break down, John Alderdice, M.D., speaker of the Northern Ireland Assembly, admits. "But if you keep lighting a candle instead of cursing the darkness, you can make a contribution," he declares.

BY JOAN AREHART-TREICHEL

With his penetrating black eyes, aquiline nose, and salt-and-pepper beard, John Alderdice, M.D., may well evoke the public's image of a psychiatrist-psychoanalyst—intellectual and a touch flamboyant. In fact, he is a psychiatrist-psychoanalyst, but more—a Lord, speaker of the Northern Ireland Assembly, and one of the key negotiators of the historic 1998 Belfast Agreement that brought some semblance of peace to Northern Ireland Catholics and Protestants, who have been engaging in open and often deadly conflict for more than 30 years.

The American Psychoanalytic Association invited Alderdice to speak at its January meeting in New York City about the Northern Ireland Protestant-Catholic situation and his role in it.

John Alderdice, M.D.: "Politics is about disagreeing with each other without killing each other."

Animosity between the Catholics and the Protestants in Northern Ireland is nothing new, Alderdice reported at the American Psychoanalytic meeting. The current "troubles" hark back to conflicts at least 800 years old and more recently to events in 1921 and 1949. They have less to do with religion than with nationalist loyalties. In 1921, as part of a peace agreement ending guerilla-style conflict against the British, the new "Free State" was created. All Irish counties were to belong to the free state with the proviso that heavily Protestant Northern Ireland could opt out; subsequently six counties in the north of Ireland chose to come under British rule. In 1949, the Free State became the Republic of Ireland, further cementing the partition.

One of the reasons that tensions between Catholics and Protestants in Northern Ireland resurfaced during the 1960s, he said, is that civil rights were making "a robust appearance on the world stage." In 1968 Northern Ireland's Catholics organized a large demonstration protesting discrimination by Northern Ireland's Protestants in voting rights, housing, and employment. A police crackdown followed, sparking months of violence. Alderdice, who was a teen at this time, said that he found the violence "exciting as well as frightening," at least until it impacted members of his own family.

During the 1970s and 1980s, Alderdice became a physician, then a psychiatrist, and then a psychoanalyst. Also, during these two decades, strife between Protestants and Catholics in Northern Ireland escalated, and Alderdice got involved in Northern Ireland politics in hopes of finding a solution to the violence. In 1978, at age 23, Alderdice, a Protestant, joined a political party that had both Protestants and Catholics in it because he thought that he could have more impact that way. It was the Alliance Party. In 1987, at age 32, he was elected leader of this party.

By 1989, some 2,700 people had died in Northern Ireland because of the 20 years of warring between Protestants and Catholics. There was tremendous anxiety

French Psychiatrist Promotes Fatty Acids For Depression Care

BY JOAN AREHART-TREICHEL

Some scientific evidence suggests that omega-three fatty acids can counter depression and perhaps bipolar disorder (*Psychiatric News*, August 3, 2001; January 16). But in France, interest in the omega-three fatty acids is extending far beyond the scientific lab.

French psychiatrist David Servan-Schreiber, M.D., has written a best-selling book called *Guérir—le stress, l'anxiété, et la dépression sans médicaments ni psychanalyse (To Heal—Stress, Anxiety, and Depression Without Medication and Without Psychoanalysis)*.

In this book, he touts the omega-three fatty acids as a natural treatment for depression. So far, the book has sold some 380,000 copies and has prompted a number of French people to buy omega-three fatty acids, according to a February 18 French television report.

Servan-Schreiber is quoted as saying on a University of Laval, Quebec, Web site: "Antidepressants are a great discovery, and they are very useful in certain cases. My book is against nothing. It is for research into efficacious natural methods and for their integration into the practice of medicine." ■

among politicians in Northern Ireland that their communities would be destroyed by the conflict, Alderdice said. So his political party and other political parties in Northern Ireland started holding talks in hopes of resolving the conflict. The talks took place regularly over the next decade and ultimately involved not just the various Northern Ireland political parties, but the governments of the Republic of Ireland and the United Kingdom; George Mitchell, a retired U.S. senator, was sent by President Bill Clinton to assist the peace process.

Finally a peace agreement—the Belfast Agreement—was signed on Good Friday 1998. The agreement gave Catholics a greater voice in Northern Ireland while meeting Protestant demands that Northern Ireland remain part of Britain. Alderdice was one of the signatories of the agreement, and he and the other signatories received the 1998 John F. Kennedy Profiles in Courage Award for their achievement. Also, after the agreement was signed, a new Northern Ireland Assembly was formed, and Alderdice was appointed speaker.

What are some of the things that Alderdice and the others involved in the decade-long talks did to achieve the Belfast Agreement?

"The most important thing was creating a culture where people who hated each other and who despised each other could work together," he said. And that meant creating a milieu where people felt respected, not humiliated. People will never forgive you if you humiliate them, he explained.

Another thing that made the talks work, he said, was inclusiveness. It took some years, but it got to a point where "all strands of the community" were represented in the talks.

Still a third thing that made the talks succeed, he said, was creating a sense of collegiality—in other words, a sense that "we're all in this mess together, and if we don't find a solution, our children and grandchildren are going to suffer."

A fourth element that led to a resolution, he pointed out, was getting politicians to think about healing broken relationships rather than "horse trading."

So where do things stand now as far as peace in Northern Ireland is concerned? In September 2003, Alderdice was appointed to the Independent Monitoring Commission established by the governments of Ireland and the United Kingdom to bring about full implementation of the Belfast Agreement. In Alderdice's opinion, Sinn Fein—the political arm of the Catholic Irish Republican Army (IRA)—now has so much political clout in Northern Ireland that it is unlikely that the IRA will resort to violence again.

Still, there are anxieties, he said. Sinn Fein fears that the Independent Monitoring Commission "is going to push them back into the darkness," and the Protestant Unionists are afraid that control of Northern Ireland is slipping away from them. Thus the challenge, he asserted, is maintaining an environment in which people on opposite sides can reflect and talk with each other directly.

Of course, the relationship between Catholics and Protestants in Northern Ireland may continue to break down, he admitted. "But if you keep lighting a candle rather than cursing the darkness, you can make a contribution," he concluded.

Stuart Twemlow, M.D., a professor of psychiatry at the Menninger Clinic in Houston, heard Alderdice's talk and spoke with him privately afterward. "He [Alderdice] instills hope because he seems to understand complex situations without oversimplifying them," Twemlow told *Psychiatric News*.

Alderdice was introduced at the American Psychoanalytic meeting by Nadia Ramzy, Ph.D., a psychoanalyst from St. Louis, Mo. Alderdice, she told her fellow analysts, is a dramatic example of how "we analysts are moving more and more into the world to help solve daunting social problems." ■

Professional News

AGLP to Present Annual Symposium

The Association of Gay and Lesbian Psychiatrists (AGLP) will present its annual symposium on Saturday, May 1, at St. Luke's-Roosevelt Hospital Center in New York City. The all-day symposium, titled "Homosexuality and Psychoanalysis: New Directions," kicks off AGLP's annual meeting, held concurrently with APA's annual meeting.

The AGLP symposium is co-sponsored this year by the St. Luke's-Roosevelt department of psychiatry, Haworth Press, the *Journal of Gay and Lesbian Psychotherapy*, and the William Alanson White Institute. The aims of the event are to bring together psychoanalytic theorists and clinicians to review the progress of the past 30 years in moving from a pathologizing perspective of homosexuality to a normative one and to outline directions for the future. According to an AGLP spokesperson, much work has been done in the last decade to refine and clarify the theoretical framework around homosexuality as a normative and parallel track of psychosexual development and to use that framework to work with lesbian and gay patients in a sensitive, well-informed way. Many of the day's speakers have been instrumental in that process.

Panels are divided into three major areas: historical perspectives, theoretical perspectives, and clinical perspectives. Presenters and discussants include Bertram Schaffner, M.D., Kenneth Lewes, Ph.D., Ralph Roughton, M.D., Elisabeth Young-Bruehl, Ph.D., Maggie Miller, C.S.W., Diana Miller, M.D., Ubaldo Leli, M.D., Ronnie C. Lesser, Ph.D., David Schwartz, Ph.D., Susan Vaughan, M.D., Rajiv Gulati, M.D., Ann D'Ercole, Ph.D., Deborah Glazer, Ph.D., Jeffrey Guss, M.D., Scott Masters, M.D., and Jack Drescher, M.D.

Registration and other information on the symposium is available from AGLP Director Roy Harker at (215) 222-2800. ■

Learning to Appreciate Psychotherapy

BY ANGELA HARPER, M.D.

All of us are aware of the residency training requirement to show competency in various types of psychotherapy prior to graduating. However, not all of us were thrilled with the idea of learning how to do this. I must admit that when I started residency almost four years ago, I was one of those individuals. I saw myself as a future clinician who would be known for her strength in psychopharmacology, not as one who would be practicing psychotherapy. Time and experience sure have a way of changing people.

I began working with patients in psychotherapy as a PGY-2. After fumbling my way through several cases, I began treating a woman using psychodynamic psychotherapy in January 2002. She initially started as a medication-management case only, but she later decided to pursue more intensive therapy and agreed to weekly sessions with me. Two years later, she has made remarkable progress. She taught me how to appreciate the importance of being skillful in psychodynamic psychotherapy to be a complete clinician. I think I have finally learned how to be comfortable with the silence in a session and to refrain from trying to "fix things" for patients. Sure, I made mistakes, but despite this, my patient stuck with me, and she got better.

As my interest in psychotherapy grew, I was asked by my training director to attend the Beck Institute's Cognitive-Behavioral Training Program in Philadelphia for one year. This involved three intensive weekend seminars and weekly phone supervision on a case of my choice. One of my patients was confronting a significant life change associated with her career and needed help changing her belief system about her capability, self-worth, and ability to cope with incredible stressors. We worked together in CBT on identifying automatic thoughts and changing core beliefs. After one year, she and I learned a lot from each other. I'm proud to say that she has succeeded, and I am grateful for the opportunity to hone my therapeutic CBT skills with her.

I can't put into words how gratifying and humbling it is when a patient shares with you that you have helped to change his or her life. Sure, we hear this same type of thing from patients who have wonderful responses to medication, but there is something special about knowing that the act of listening, interpreting, gently confronting, and supporting can change a life by itself. My experience has been so positive that I have decided to continue working with patients in psychotherapy, along with psychopharmacology, once I begin in private practice.

When I think back to my initial resistance about psychotherapy, I can't help but think about why some of us shy away from learning how to be good therapists. I believe that it has to do with our fear of the unknown. You can't teach this skill by hearing lectures about it. You simply have to jump in with both feet, make mistakes, learn via trial by fire, and utilize the wisdom and expertise of your supervisors along the way. Learning how to do this well is an integral part of what we do. It's what makes us different from other doctors who can just as easily prescribe medicines. Even if you never practice psychotherapy after your training is completed, understanding and appreciating the importance of what makes people the way they are and how they got to be that way are crucial to providing good patient care.

If you have any questions or concerns or if you are interested in writing an article for the Residents' Forum, please contact me by e-mail at a_d_harper@yahoo.com. ■

Professional News

Indo-American Psychiatrists to Meet In New York City

The Indo-American Psychiatric Association (IAPA) will celebrate its 25th anniversary during APA's 2004 annual meeting in New York City with a scientific meeting and evening dinner meeting.

The IAPA's scientific meeting will be held Sunday, May 2, from 1:30 p.m. to 4:30 p.m. at the Crystal Ballroom of the Ramada New Yorker Hotel on the topic "American-Born Confused Desi (ABCD): Myth or Reality?" Boxed lunches will be served. The IAPA invites Indo-American Psychiatrists to submit poster presentations for the meeting. No advance registration is required.

There will also be an evening dinner meeting for which registration is required. The date and location of the meeting will be announced in a future issue. Awards will be given in the categories of scientific contributions, service, public psychiatry contributions, outstanding trainee, and special achievement. Other prominent contributions and achievements will also be recognized.

More information about the meeting is available by calling (516) 292-9741 or sending an e-mail to apandya880@hotmail.com. ■

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ional News

APA Fall Institute Garners Rave Reviews

Active involvement by the Massachusetts Psychiatric Society helped to make last year's Institute on Psychiatric Services a big hit with attendees.

BY EVE BENDER

Nearly 2,000 people attended APA's 2003 Institute on Psychiatric Services in Boston last fall, exceeding attendance figures for the previous two years. Furthermore, according to a report evaluating the meeting, more than 98 percent of registrants rated the meeting's sessions excellent.

In response to suggestions from attendees at the 2002 meeting, the institute's Scientific Program Committee included more than 150 sessions on topics such as substance abuse, child and adolescent psychiatry, and alternative and complementary medicine in psychiatry.

The 2003 institute was the first held in conjunction with the American Association of Community Psychiatrists, some of whose members sat on the Scientific Program Committee and helped to plan the meeting sessions. Total attendance was 1,875.

A report from APA's Department of Continuing Medical Education highlighted these and other data from the meeting, including comments from attendees. Kathleen Debenham, M.A., who is director of that office, prepared the report.

"Boston, a meeting site with numerous medical schools and an active APA district branch," was a factor in last year's increased attendance levels, according to the report.

"The Scientific Program Committee established a very successful working relationship with the Massachusetts Psychiatric Society and was able to utilize the society's members for promotion of the institute as well as for identification of local faculty for the program," Debenham said.

General evaluation forms were placed in all registration packets and distributed to attendees at a variety of locations at the meeting. A computerized evaluation survey allowed meeting registrants to complete the evaluation process online. In addition, forms were mailed to nonrespondents after the meeting.

Ninety-eight percent of the 508 registrants who completed the general evaluation survey rated the overall quality of the educational sessions as excellent, and 99 percent agreed that the sessions met their educational objectives.

About 78 percent of registrants thought that the industry-supported symposia provided a balanced view of the topics covered, though 93 percent said that within the sessions, multiple views were presented.

Eighty-nine percent of respondents said that their professional effectiveness will be enhanced as a result of their participation in the meeting.

Psychiatrists made up the highest percentage of the registrants at the meeting (45.7 percent), and among these were 775 APA members. The second-highest population was residents (19.5 percent). Psychologists, social workers, occupational therapists, and nurses made up 12 percent of registrants.

Recommendations for the 2004 institute included increasing the call for submissions for industry-supported sessions, especially among minorities; implementing a new plenary session format; and seeking continued funding for the Chief Residents Executive Leadership Program.

The 2004 Institute on Psychiatric Services will be held October 6 to 10 in Atlanta. More information on the 2004 institute is posted online at <www.psych.org/edu/ann_mtgs/ips/04/index.cfm>. ■

Nominations Invited For Minority Fellowship Achievement Award

APA is seeking nominations for its 2005 Jeanne Spurlock Minority Fellowship Achievement Award. This award recognizes the outstanding achievements of alumnae and alumni of the APA minority fellowships and encourages continued involvement in the fellowship program. (A list of alumnae and alumni is posted online at <www.psych.org/edu/other_res/apa_fellowship/minorityfellowalumnilist.cfm>).

Nominations should include a brief letter describing the nominee's contributions and details about his or her qualifications for the award and the nominee's curriculum vitae. The deadline for receipt of nominations is April 30.

Previous winners include Irma Bland, M.D., William Lawson, M.D., and Patricia Ordorica, M.D. This year's winner is former fellow Mindy Thompson Fullilove, M.D., a professor of clinical psychiatry and public health and a research psychiatrist at the New York State Psychiatric Institute.

Nominations should be sent to Evaristo Akerele, M.D., Chair, APA/SAMHSA Selection and Advisory Committee, APA, Department of Minority/National Affairs, Suite 1825, MS#2038, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. ■

Another Residency Program Joins APA's 100% Club

The residency training program in the department of psychiatry at Albert Einstein Medical Center in Philadelphia is the eighth program to have all of its psychiatry residents become members of APA.

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

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

(The first year of membership at the national level of APA is free for residents and $80 thereafter for U.S. residents and $45 for Canadian residents. Membership for medical students is free.)

From left to right: Michael Vergare, M.D. (chair), Kimberly Best, M.D. (program director), Cynthia Fonder, M.D., Nancy Diaz Granados, M.D., Shane Danielson, M.D., Katherine Napalinga, M.D., Christine Evangelista, M.D., Ushma Patel, M.D., Edgar Martinez, M.D., Ahmed Hefuna, M.D., Iris Vivas, M.D., Imnas Coquia, M.D., Vasco Daubon, M.D., Ron Suarez, M.D., Christian Kcomt, M.D., John Balaicius, M.D., Kishore Desagani, M.D., Francis Keating, M.D., Melanie Akalal, M.D., Nader Galal, M.D., Chong Kim, M.D., Aimee Alinsonorin, M.D., Deepti Jain, M.D., Guillermo Otero-Perez, M.D., Francis Sanchez, M.D., Leo Cevallos, M.D., and Sudhakar Morthala, M.D. (chief resident).

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

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Dining Delights Over the River And Through the Tunnel

When it comes to dining well in New York City, think outside the island. Many of the city's palette-pleasing eateries will take you beyond Manhattan and expand your knowledge of the city.

BY DAVID MCDOWELL, M.D.

I don't know about you, but I feel like going out to eat this evening in a pair of jeans and a T-shirt. Anything but a suit and tie. Not tonight. I want good food, good service, a low-key atmosphere, no pretension, and a place where I won't feel out of place wearing something casual. OK, maybe jeans and a T-shirt won't suffice at some of the suggestions below—but you get my drift. Comfort. And not the usual space. A place that I wouldn't find elsewhere. In other words: unique.

So take off that suit and tie or that formal business dress, get yourself a Metrocard, and get thee to **The Grocery**!

No. I don't mean Safeway, Vons, Dag's, Ralph's, Whole Foods, or any of the other names you might know when referring to "the grocery." Nope. The Grocery is a very small (one room, and a small one too) that serves up some of the best food in all of New York City and a place where casual dress, low-key surroundings, and no pretension rule. (Note to the Borough phobic: it's in Brooklyn. Oh no!).

Ah, The Grocery. The room is spare. There's nothing to "see." It's not for those looking for a scene. It's for eating. And eating well. Well beyond well. Sublime food. Outstanding service. And you know what? You can do it all in your most casual wear. OK, sure, you have to go to Brooklyn. Come on! It's not Siberia! It's Brooklyn! It's one of the most sought-after destinations for dining these days in New York City. Especially Smith Street. It's in Carroll Gardens, which is an old and still thriving Italian neighborhood. (You can still see your ancient grandmother peering out of her bedroom window and watching the street to make sure there's nothing amiss.)

If The Grocery is full, then just walk around. There's always **Patois**—the place that set up shop first in this neighborhood. Bistro-ish, warm, and friendly. An icon of the 'hood. Or maybe you feel like Mexican food. All right then. I've got you covered.

Walk on over to **Alma** and have a taste of Gary Jacobson's superb fare. The main room is incredible. In good weather, the roof-top deck, with its stunning view of Manhattan, is open for dining. And if that isn't enough, they have this great bar on the lower level called B61. It's this crazy mix of locals and the adventurous. The bar is awesome, and the jukebox is incredible.

What? You've read about the infamous Park Slope neighborhood in Brooklyn? Then why not head on over? And when you do, it's **Al Di La** you need to head toward. The restaurant doesn't take reservations, so be warned that there might be lines. And it's communal seating. So get over it, meet some locals, and eat! If you want authentic Venetian, there might not be a better choice than here.

But I think I heard you say you're tired. You just want some pizza and a good beer. You can't think anymore. You just want a place where you can deal with nothing more than saying, "Large. And some brew." You've come to **Grimaldi's,** on Brooklyn's famed waterfront. A legend in New York pizza. Thin crust and coal-oven baked. You'll thank yourself that you had the foresight to eat here. Just come on in and settle back. Order a simple, classic New York pizza and a beer. Eat. You are now in heaven.

Brooklyn isn't your gig? You want something a little closer to the midtown trains? What? You don't want to take a train? Then how about taking a ferry? Yeah, a ferry! That would mean you're having dinner at

please see ***Dining*** *on page 82*

David McDowell, M.D., is a member of APA's Scientific Program Committee.

How to Register

There are two easy ways for APA members to register for APA's 2004 annual meeting, which is being held May 1 to 6 in New York City:

- Go to APA's Web site at www.psych.org, click on "2004 APA Annual Meeting," and select "Online Registration for Members." Also, reserve your hotel room by clicking on "APA Members Reserve Your Hotel Online."
- Fill out the forms in the 2004 Annual Meeting Advance Registration Information packet, which was mailed to all members last month. If you have not yet received your packet, call the APA Answer Center at (888) 35-PSYCH; from outside the U.S. and Canada, call (703) 907-3800.

The deadline for advance registration is **April 3**.

annual meeting

Spiritual Leader to Guide Psychiatrists From the Head to the Heart

Take time to improve your well-being and sense of peace by attending a lecture by an internationally recognized spiritual leader.

BY PHILIP MUSKIN, M.D.

Sri Sri Ravi Shankar, a renowned spiritual leader, will be the 2004 International Lecturer at APA's 2004 annual meeting this year in New York City. He is the founder of the International Association for Human Values (IAHV) and the Art of Living Foundation.

Philip Muskin, M.D., is a member of APA's Scientific Program Committee.

In his lecture, "Psychiatry and Spirituality: A Holistic Approach," Shankar will discuss the introduction of unique applications of the mind/body/spirit concept and how these concepts are used for the treatment of anxiety, depression, trauma, violence, and stress-related disorders.

The lecture will be held Monday, May 3, from 9 a.m. to 10:30 a.m. at the Javits Convention Center.

Shankar has promoted religious tolerance, peace, and innovative social programs in his numerous public addresses including the United Nations World Peace Summit (2000), for which he was the keynote speaker; the World Economic Forum (2000, 2002); and the United Nations Conference on Racism and Discrimination (South Africa, 2001).

Research has shown that the special yoga breathing techniques and teachings of the Art of Living courses effectively relieve stress and increase energy, awareness, mental focus, and sense of belonging. The effects have been demonstrated in a wide range of populations including health care practitioners; individuals with psychiatric and medical conditions; children and adolescents; prison inmates and staff; juvenile offenders; and victims of natural disasters, poverty, violence, war, and terrorism.

Art of Living courses and IAHV humanitarian relief programs in more than 100 countries have improved the lives of millions of individuals by sending volunteers, teachers, and medical staff to provide trauma relief and promote nonviolent conflict resolution in many. A partial list of the areas served includes Serbia, Croatia, Kashmir, Afghanistan, Iraq, Iran, Israel, Africa, South America, the former Soviet Union, Eastern Europe, Western Europe, Far East, United States, Australia, and Canada.

Sri Sri Ravi Shankar reminds us to journey from the head back to the heart as we care for our patients, our local communities, and our world community. ■

Professional News

Analysts to Meet In New York

Come to the annual meeting early so you can attend another major psychiatric meeting as well.

The American Academy of Psychoanalysis and Dynamic Psychiatry will hold its 48th Annual Meeting in New York City at the Sheraton New York Hotel from Thursday, April 29, through Sunday, May 2, contiguous with APA's annual meeting.

The theme of the meeting is "Psychodynamic Education, Assertive Approaches." For several decades, the teaching of psychoanalytic and dynamic precepts has waned in general psychiatric education. Now residents and attending psychiatrists have begun to seek more understanding of the ways to approach their patients through dream interpretation, transferential analysis, and behavioral motivation. Residency review committees are requiring proficiency in dynamic psychiatry as well.

The program is designed to approach these objectives in several ways: panelists will present the overview of what is right and what is wrong in psychodynamic education and where it needs to go. There will be workshops on supervision, use of videotaping, and use of pharmacology and neurobiology to teach an integrated comprehension using writing, dreams, and therapeutic failure. In addition, case presentations and interpretations will be made by respected senior analysts from Europe and America. Stressing the juncture of dynamics with the field of psychiatry as a whole, the keynote address will be given by APA President Marcia Goin, M.D. The opening talk will be given by Samuel Klagsbrun, M.D., a noted author and educator.

Psychiatry has always ventured outside the examining room and worked with human issues and rights. In honor of the dedication and courage of Judd Marmor, M.D., who died in December, a special panel will examine his life, his work, and his contributions to humanism and therapy. In honor of Alexandra Symonds, M.D., a full-day symposium will take place on Saturday, May 1, focusing on women, anger, and assertiveness from the Renaissance to today, noting characteristics of particular racial and religious groups constructively working on solutions. Discussion groups and a luncheon will encourage participation and sharing by audience members.

More information can be obtained by calling (888) 691-8281 or visiting the Web site <www.aapsa.org/academy_meetings.html#48th_Annual_Meeting>. The program is accredited for Category 1 ACCME credit. ■

Learn the Latest On Addiction Science

APA's 2004 annual meeting will include a special research-based program track presented in collaboration with the National Institute on Drug Abuse, titled "Integrating the Science of Addiction Into Psychiatric Practice." This special track will raise awareness of new and emerging issues in addiction and psychiatry and provide important information related to best practices and treatment strategies. More information on the series is available by contacting Beatrice Eld Edner at (703) 907-8598 or bedner@psych.org.

Monday, May 3

9 a.m.-10:30 a.m.

Lecture 2
Signal Integration in the Brain
Paul Greengard, Ph.D.
Javits Center, Level 1, Rooms 1E07/8

Issue Workshop 6
Drug Abuse and Suicidal Behavior
Chair: Eric D. Caine, M.D.
Javits Center, Level 3, Room 3D02/11

Issue Workshop 16
Cocaine and Tobacco Use During Pregnancy: Adverse Outcomes in Offspring
Chair: Vincent L. Smeriglio, Ph.D.
Marriott Marquis, Seventh Floor, Empire/Hudson Rooms

11 a.m.-12:30 p.m.

Issue Workshop 26
Obtaining Research Funding From NIH: Keys to Successful Grant Writing
Chair: Lucinda L. Miner, Ph.D.
Marriott Marquis, Seventh Floor, Empire/Hudson Rooms

2 p.m.-5 p.m.

Symposium 3
Functional Brain Imaging of Addiction
Chair: Elliot A. Stein, Ph.D.
Javits Center, Level 1, Room 1E09

- Neuropsychiatric Implications of Mapping Reward/Aversion Circuitry
- Endogenous Opioid Neurotransmissions: Interfacing Reward and Stress Regulation
- Chronic Effects of Drug Use and HIV
- Neurobiological Substrates of Stimulant Action and Reward

Symposium 4
Treatment of Chronic Pain in Recovering Addicts
Chair: Jag Khalsa, Ph.D.
Javits Center, Level 1, Room 1E11

- Pain Assessment and Issues in Screening
- Assessing Aberrant Drug-Taking Behaviors in Medically Ill Patients With Pain
- The Development and Treatment of Opioid-Induced Hyperalgesia
- Prescribing Pain Medications for Recovering Addicts With Chronic Pain
- Principles of Pain Treatment in Addictive Disorders

Symposium 22
Obesity: Lessons Learned From Addiction
Chair: Joseph Frascella, Ph.D.
Discussant: Nora D. Volkow, M.D.
Marriott Marquis, Seventh Floor, Empire/Hudson Rooms

- Genetic, Motivational, and Metabolic Factors Modulate the Neural Drive to Maintain Body Weight
- Cortico-Striatal-Hypothalamic Networks and Motivation for Food: Integration of Cognition, Reward, and Energy
- Food and Drug Cravings: Metaphor or Common Mechanism?
- Common and Diverging Neurobiological Features of Feeding and Drug Self-Administration in Humans
- Obesity and Addiction: Neuroimaging Studies

Symposium 24
Genetic and Environmental Factors Contributing to Vulnerability to Addiction
Chair: Jonathan D. Pollock, Ph.D.
Marriott Marquis, Ninth Floor, Cantor/Jolson Rooms

- Using Twin Data to Identify Alternative Drug-Abuse Phenotypes
- Common and Specific Genetic Factors in the Development of Substance Dependence
- Addiction Molecular Genetics: Remarkably Converging Results
- Using the Systems Biology of Motivation for Genetic Studies in Psychiatry
- Genetic and Environmental Factors Modulate Cocaine Abuse in Monkey Models

Tuesday, May 4

9 a.m.-10:30 a.m.

Distinguished Psychiatrist Lecture 13
Why Does the Human Brain Become Addicted?
Nora D. Volkow, M.D.
Javits Center, Level 1, Room 1E15

Issue Workshop 45
Steroid Abuse: Growing Problem for Adolescents and a Hidden Problem for Adults
Chair: Donald R. Vereen, Jr, M.D.
Marriott Marquis, Fifth Floor, Alvin/Carnegie Rooms

Issue Workshop 48
Emerging Pharmacotherapies for Treatment of Stimulant Dependence
Chair: Francis J. Vocci, Ph.D.
Marriott Marquis, Fifth Floor, Imperial/Julliard Rooms

Issue Workshop 56
Addiction Research as a Career Choice in Psychiatry
Chairperson: Ivan D. Montoya, M.D.
Marriott Marquis, Seventh Floor, Herald/Soho Rooms

9 a.m.-11 a.m.

Research Advances in Medicine
The Epidemiology and Treatment of Psychiatric Comorbidities
Chair: Geetha Jayaram, M.D.
Co-Chair: Joel J. Wallack, M.D.
Javits Center, Level 1, Room 1E09

- Epidemiology of Comorbid Psychiatric and Addictive Disorders
- Comorbidity of Psychiatric and Addictive Disorders in Children
- Depression in Hepatitis C Patients and Interferon Treatment
- Research Advances in HIV Care

11 a.m.-12:30 p.m.

Frontiers of Science Lecture 15
Anticraving Medication: New Class of Psychoactive Medication?
Charles P. O'Brien, M.D.
Javits Center, Level 1, Room 1E15

Issue Workshop 74
Drugs and Other Addictions: Does One Size Fit All?
Chair: Steven J. Grant, Ph.D.
Marriott Marquis, Seventh Floor, Herald/Soho Rooms

Issue Workshop 75
Stress, Trauma, and Drug Abuse
Chair: Nancy Pilotte, Ph.D.
Marriott Marquis, Ninth Floor, Marquis Ballroom Salons A/B

2 p.m.-3:30 p.m.

Frontiers of Science Lecture 18
Conceptual and Methodological Flaws in the Evaluation of Addiction Treatment
A. Thomas McLellan, Ph.D.
Hilton New York, Third Floor, Trianon Ballroom

2 p.m.-5 p.m.

Symposium 42
Smoking and Comorbid Mental Disorders
Chair: John R. Hughes, M.D.
Javits Center, Level 3, Rooms 3D06/7

- Psychiatric Comorbidity of Smoking and Nicotine Dependence: An Epidemiologic Perspective
- The Neurobiology of Nicotine Dependence and Comorbid Psychiatric Disorders
- Nicotine-Dependence Treatment in Individuals With Schizophrenia
- Behavioral and Pharmacological Treatments for Smokers With Depression

Symposium 55
ADHD Subtypes and Subgroups at Risk for Substance Use Disorders
Chair: Naimah Z. Weinberg, M.D.
Marriott Marquis, Seventh Floor, Herald/Soho Rooms

- Subtypes of ADHD Youth At Risk for Substance Abuse
- Childhood ADHD, Comorbidity, and Risk for Late-Adolescent Drug Abuse
- Developmental Twin Studies of Relations Between Substance Use and ADHD
- Variability in Risk for Substance Use and Disorder Among Children Diagnosed With ADHD
- Behavioral and Cognitive Predictors of Adolescent Substance Use in Children With ADHD
- Long-Term Follow-Up of Childhood ADHD: Development of Adult Substance Abuse

Wednesday, May 5

9 a.m.-10:30 a.m.

Issue Workshop 82
Treatment of Patients With Drug Dependence and Psychiatric Illness
Co-Chair: Roger D. Weiss, M.D.
Co-Chair: Wilson Compton III, M.D.
Javits Center, Level 1, Room 1E12

11 a.m.-12:30 p.m.

Distinguished Psychiatrist Lecture 21
Stress and Relapse to Substance Use Disorders
Kathleen T. Brady, M.D.
Javits Center, Level 1, Rooms 1E07/8

2 p.m.-5 p.m.

Symposium 80
Consequences and Treatment of Marijuana Abuse
Chair: Susan R.B. Weiss, Ph.D.
Co-Chair: Jag Khalsa, Ph.D.
Marriott Marquis, Fifth Floor, Imperial/Julliard Rooms

- Cognitive Toxicity of Cannabis: The Devil Is in the Confounding Variables
- Cognitive Effects in Adolescents Exposed Prenatally to Marijuana or Cigarettes
- Effects of Chronic Marijuana Use and THC on Brain Function in Humans: A fMRI Study
- Behavioral and Treatment Research on Marijuana Withdrawal and Dependence
- The Endogenous Cannabinoids and the Control of Drug Craving

Symposium 84
Moving the Targets: The Neurobiology of Addiction
Chair: Nancy Pilotte, Ph.D.
Marriott Marquis, Seventh Floor, Columbia/Duffy Rooms

- Neuroadaptation in Addiction: The Extended Amygdala and Brain-Reward System
- Neural Circuitry of Relapse
- Drugs, Neuroplasticity, and Addiction
- How Do Drugs of Abuse Rewire the Motivational Circuitry?

Symposium 85
Drug Abuse Treatment Issues in Women
Chair: Cora Lee Wetherington, Ph.D.
Marriott Marquis, Seventh Floor, Empire/Hudson Rooms

- Gender Differences in Treatment Needs, Services, Utilization, and Outcomes
- Treatment Issues in Drug-Dependent Women With Comorbid Depression
- Trauma and PTSD: Issues in the Treatment of Drug-Dependent Women
- Drug-Dependent Women With Partner Violence: Treatment Issues
- Drug-Treatment Issues in Drug-Dependent, Pregnant Women

Thursday, May 6

2 p.m.-5 p.m.

Symposium 96
Behavioral Treatments for Drug Dependence
Chair: Lisa S. Onken, Ph.D.
Co-Chair: Bruce J. Rounsaville, M.D.
Javits Center, Level 1, Room 1E13

- Durability of Cognitive-Behavioral Therapy Efficacy for Substance Abusers
- HIV Risk Reduction and Substance Abuse Treatment
- Low-Cost Contingency Management in Community Settings
- Cognitive-Behavioral Therapy and Naltrexone for Cocaine Dependence
- Behavioral Family Counseling and Naltrexone for Male, Opioid-Dependent Patients

In Memoriam

APA honors the following members whose deaths were reported to APA from November 1, 2003, to January 30. All deceased APA members are remembered at APA's annual business meeting, held each year at APA's annual meeting.

Edward C. Adams, M.D.
Orinda, Calif.

Milton H. Anderson, M.D.
Evansville, Ind.

Nathaniel Apter, M.D.
Peoria, Ariz.

Philip A. Baratta Jr., M.D.
La Jolla, Calif.

Carole Joyce Barry, M.D.
Albuquerque, N.M.

Lillian F. Bennett, M.D.
San Francisco, Calif.

Nathan K. Bernstein, M.D.
New Hartford, N.Y.

Stanley Bernstein, M.D.
New York, N.Y.

John Alden Bowman, M.D.
Kokomo, Ind.

Norman S. Brandes, M.D.
Columbus, Ohio

Bruce Braverman, M.D.
New York, N.Y.

Irving L. Breakstone, M.D.
Miami, Fla.

Dana Charry, M.D.
Princeton, N.J.

Edwin B. Dakay, M.D.
Henderson, Nev.

Rafael G. Dufficy Jr., M.D.
Greenbrae, Calif.

Merton L. Ekwall, M.D.
Tallahassee, Fla.

Morton L. Enelow, M.D.
Guilford, Conn.

Katherine A. Enright, M.D.
Chapel Hill, N.C.

Dan W. Everett, M.D.
Canon City, Colo.

H. L. Gartshore, M.D.
Oakland, Calif.

John C. Gillin, M.D.
San Diego, Calif.

Frederic Grunberg, M.D.
Montreal, Quebec

David A. Halperin, M.D.
New York, N.Y.

Inam Ul Haque, M.D.
Oshkosh, Wis.

Ludmila Harbar, M.D.
Brantford, Ontario

Emerson G. Hiler, M.D.
Redlands, Calif.

Waunell M. Hughes, M.D.
Dallas, Tex.

Morris Isenberg, M.D.
Forest Hills, N.Y.

Maria B. Izquierdo, M.D.
Corpus Christi, Tex.

Paul S. Jarrett, M.D.
Miami, Fla.

Samuel W. Joel, M.D.
Belmont, Mass.

Max E. Johnson, M.D.
New Orleans, La.

Joseph P. King, M.D.
Indianapolis, Ind.

Zigmond Meyer Lebensohn, M.D.
Washington, D.C.

S. Michael Lesse, M.D.
Easton, Pa.

Susann L. Lovejoy, M.D.
Huntington, W.Va.

John W. Markson, M.D.
Brookline, Mass.

Judd Marmor, M.D.
Los Angeles, Calif.

Theodore Nadelson, M.D.
Brookline, Mass.

Ilgvars J. Nagobads, M.D.
St. Petersburg, Fla.

Ruben Nazario Rodriguez, M.D.
Rio Piedras, Puerto Rico

Stanley L. Olinick, M.D.
Bethesda, Md.

Gordon W. Petersen, M.D.
Evergreen, Colo.

Paul S. Pressman, M.D.
White Plains, N.Y.

Robert Merle Ritter, M.D.
Brandon, Miss.

Leonard M. Rothstein, M.D.
Owings Mills, Md.

Jerome Ruderman, M.D.
Englewood Cliffs, N.J.

Donald C. Sanders, M.D.
Shawnee Mission, Kan.

Myron Guy Sandifer Jr., M.D.
Lexington, Ky.

Irene Sargent, M.D.
Redwood City, Calif.

Hilde Schlesinger, M.D.
San Francisco, Calif.

Margaret M. Sedberry, M.D.
Austin, Tex.

Henry Z. Shelton, M.D.
Englewood, N.J.

William M. Shipman, M.D.
Del Mar, Calif.

Henry K. Silberman, M.D.
Richmond, Va.

Alim Sipahi, M.D.
Brooklyn, Mich.

Zalec I. Skolnik, M.D.
Great Neck, N.Y.

Rita R. Spies, M.D.
Oakland, Calif.

Moises Sucholeiki, M.D.
Jacksonville, Fla.

Samuel Susselman, M.D.
San Francisco, Calif.

Joyce Root Tedlow, M.D.
Waban, Mass.

Clara Torda, M.D., Ph.D.
Brookline, Mass.

Julian Tosky, M.D.
Palo Alto, Calif.

Jorge Alberto M. Vargas, M.D.
Oklahoma City, Okla.

Jose M. Vilanova, M.D.
Pittsburgh, Pa.

William G. Young, M.D.
Los Gatos, Calif.

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Advice for New Practices, New Careers

Q. I am working for the state and no longer require individual coverage through the Psychiatrists' Program. When I was a participant in the Program, I found that the risk management services were exceptional and tailored to psychiatry. As the information is still relevant in my current setting, I am writing to ask whether it is possible to subscribe to your quarterly newsletter, *Rx for Risk?*

A. Yes. Current participants in the Psychiatrists' Program, the APA-endorsed Psychiatrists' Professional Liability Insurance Program, already know the benefits of receiving *Rx for Risk*. Written by experts in psychiatric risk management, this quarterly publication is specifically designed for psychiatrists and covers current risk management and legal issues affecting the field of mental health care.

These are some of the articles featured in previous issues of *Rx for Risk:*

- Emergency Medical Treatment and Labor Act (EMTALA): The Challenge of Compliance in Psychiatric Cases
- How to Handle Litigation-Related Requests for Patient Information Under HIPAA's Privacy Rule
- Brain Lesions v. Psychiatric Disorders: Malpractice Implications
- Termination of the Psychiatrist-Patient Relationship
- Keeping Risk Management Current With Electronic Devices
- Stolen Medical Records and the Threat of Identify Theft
- Supervision of Nurse Practitioners
- Supervision of Medical and Nonmedical Mental Health Care Professionals
- Office Staff, Risk Management, and You
- What Allegations in Post-Suicide Malpractice Lawsuits Can Teach About Risk Management Strategies

If you are not a participant in the Program and would like a subscription to *Rx for Risk*, please call (800) 245-3333, ext. 347, or send an e-mail to editor@prms.com. Annual subscriptions (four issues) are available for $79. A subscription form can be mailed or faxed to you.

Q. I am forming a group practice with two other psychiatrists, several psychologists and social workers, and two nurse practitioners. Do you offer insurance coverage for such a group?

A. Yes. The Program offers professional liability insurance to behavioral health care professionals practicing in a group setting. The many benefits of the individual program, including risk management services, are extended to the corporate entity and everyone associated with it.

Psychiatrists, psychologists, social workers, and independent contractors practicing in a group can be covered under one policy with separate limits and still maintain a single defense under one claim if the situation ever arises. For more information on obtaining group liability coverage, contact Jacqueline Palumbo at (800) 245-3333, ext. 314, or visit <www.psychprogram.com>.

Q. As a participant in the Program, I have found the Risk Management Consultation Service (RMCS) to be an excellent resource. Is there a limit to how many times I can call the RMCS to receive risk management advice and guidance?

A. The RMCS is a value-added service for Program participants. You are encouraged to contact us whenever a request or situation is troubling you or is raising questions or concerns. No question is insignificant or frivolous, but there are significant questions that are not asked. These unasked questions may increase your risk. In fact, the greatest risk may lie in not asking.

Program risk managers routinely respond to a broad range of questions, such as

- I am seeing a patient who is a minor. One of his parents is requesting information that I am uncomfortable releasing. What can I do?
- How do I properly document a patient's informed consent?
- What should be included in an information-release authorization?
- How long do I have to keep my records?
- I have just received a subpoena for patient records in a lawsuit that does not involve me. Do I have to comply? If so, how do I comply without breaching confidentiality?
- How do I end a physician-patient relationship when the patient doesn't want to end treatment with me?
- I share office space with others. Should I be doing anything more to reduce my risk of being sued by my office mate's patient?

You may call the RMCS toll free Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Time, or you may submit a risk management question through the RMCS page in the "For Participants Only" section at the Web site <www.psychprogram.com>.

Q. I have heard about the importance of investigating the ratings for insurance carriers when making an insurance purchase decision. What are the ratings for the Psychiatrists' Program's carrier?

A. Coverage is issued through National Union Fire Insurance Company of Pittsburgh ("National Union") and Lexington Insurance Company, two member companies of American International Group Inc. (AIG). AIG companies consistently earn high rankings from the insurance industry's principal rating agencies: A++ by A.M. Best and AAA by Standard and Poor's.

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

Bush's '05 Budget for Health Services, Research Falls Short

BY EUGENE D. CASSEL, J.D.
NICHOLAS M. MEYERS

A recent headline read "Bush Budget: Medicaid, 128 Other Nondefense Programs Face Cuts."

Indeed, since President Bush released his Fiscal 2005 budget proposal last month (see page 6), it has become a budget known for its record size, its cuts, and the deficit it projects—$521 billion—in spite of those cuts.

The plan is also notable for including the start of funding for what could be a hugely expensive effort to visit Mars and for renewing the president's call for making permanent the tax cuts he has put through Congress.

President Bush's election-year budget blueprint calls for a total of $2.4 trillion in federal spending; a reduction in numerous programs in the face of record federal deficits and the costs of war; and a half a percent *increase* in domestic discretionary spending, the umbrella under which most health- and research-related expenditures fall.

While there is some good news in the budget for programs of interest to APA, we must also underscore that the rates of increase in funding for many of the programs, particularly with regard to the National Institutes of Health, do not keep pace with medical inflation.

In general, APA's strategy will be to call on Congress to provide additional funds for vital programs.

Many of the increases in health- and research-related expenditures are tied to protecting the homeland from bioterrorism, as opposed to providing services or conducting more general research.

Here are some highlights of the president's Fiscal 2005 budget request:

• His plan calls for $572 billion in spending for Health and Human Services, a 2.8 percent increase—but a 1.6 percent reduction in its discretionary funding. The overwhelming majority of HHS funding is for Medicare (50.3 percent) and Medicaid (31.5 percent).

• The Medicare drug benefit recently signed into law continues to grab headlines as the Office of Management and Budget projects it will cost $139 billion more over 10 years than the Congressional Budget Office had estimated. No significant Medicare legislation is expected this year; instead, the administration's focus will be on the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

• The National Institutes of Health, under the president's plan, would receive $28.8 billion in Fiscal 2005, which is a 2.7 percent increase over Fiscal 2004. The budgets of the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism would grow similarly. But since these rates of growth keep pace with neither medical inflation nor research opportunities, APA and its allies are lobbying Congress to add funds.

• The Substance Abuse and Mental Health Services Administration would get 6 percent more than in Fiscal 2004. The Center for Mental Health Services, in particular, would get substantial new funds to support, through grants, the development of comprehensive state mental health plans to reduce system fragmentation and increase services. In contrast, community grant programs for jail-diversion projects and for improved services to the elderly are slated to lose $7.5 million, which APA is lobbying aggressively to restore.

• The Department of Veterans Affairs would get an 8.3 percent increase over Fiscal 2004, although the VA's discretionary spending budget would increase by just 1.8 percent. The president is proposing again the instituting of charges to some veterans for access to VA hospitals, but that proposal is controversial and failed to win passage last year. VA research funding would decrease by 6.1 percent overall, which APA is lobbying to restore.

• The Health Resources and Services Administration's budget would decrease by 9.3 percent. Increased funding for health centers is slated, which would fund 1,200 new centers by the end of Fiscal 2006, but Title VII health professions programs would face deep cuts—96 percent below Fiscal 2004, inflicting extensive damage on scholarships for disadvantaged students, which we are lobbying to prevent.

• The president requested that the Indian Health Service (IHS) receive $497 million (a 3.8 percent increase) to purchase health care from non-IHS hospitals and health providers. Despite the proposed increase in service funding, the 4 percent increase in provider payments that the president had promised is not included in his budget, so APA, as part of the Friends of Indian Health Coalition, is lobbying for it. ■

Eugene D. Cassel, J.D., is special counsel and director of APA's Division of Advocacy. Nicholas M. Meyers is director of APA's Department of Government Relations.

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One Path to a Research Career

BY EVARISTO AKERELE, M.D.

The recent report by the Institute of Medicine on the serious dearth of psychiatrists choosing research careers highlighted ways in which the government and training programs could make a research career more attractive. One such avenue, however, already exists, and I would like to explain how those of you contemplating research careers can take advantage of it.

The mentored career-development award (K23, K12, K08) sponsored by the National Institutes of Health (NIH) is probably the best modality for helping psychiatrists become researchers. This can be obtained by applying to one of the institutes that are part of the NIH. Most psychiatrists apply to either the National Institute on Drug Abuse or National Institute for Mental Health.

The research career development award provides 75 percent of your salary, with your home institution putting up the rest. This funding formula ensures that your time is protected and can be devoted to research rather than a second job to supplement your income. In addition, it provides adequate funds for the researcher to employ a research assistant. This article will address the preparation, writing, and submission of material to obtain a career-development award.

The first step in preparation for the K award is to choose a research fellowship with a strong track record in developing researchers. This should be as close as possible to your area of interest. Next, you need a mentor and a niche. It is important to realize that you may have one key mentor who is an expert in the topic or field on which you have chosen to focus but several others in various aspects of your career development.

The next step is to learn about effective grant writing, either at conferences, your institution, or both. Our psychiatry department has annual K award training sessions. In addition, our division of addiction psychiatry has an unofficial grant-review body. No grant application leaves the division without the express approval of several members of this group. Ultimately, learning has to be by doing. Writing a grant proposal forces you to think through your ideas critically and becomes a central learning experience in terms of mastering the scientific field on which you are focusing.

Research fellowships generally last two years. During the first year, you should write a protocol and a review paper related to your area of concentration and start gathering data for your pilot study. Then analyze the data, present the data at a scientific meeting, and start plans to publish in a peer-reviewed journal. At the end of your first year as a fellow, establish with your mentor a timeline for your K award application. You will need at least three months to write an application that has a good chance of being successful. Generally, multiple drafts and revisions are needed to develop an excellent proposal.

Probably the most time-consuming part of your K award application will be the "Specific Aims and Background" section. A thorough review of the literature is necessary. The aims section ideally should fit on one page. The background section is a more-detailed expansion of the aims section. Both sections combined should be no more than six or seven pages.

The next area of great significance in this race against time is the design and methodology section. This is the scientific heart of the proposal and is necessary for writing the budget. You will need help from your departmental administrator or business office in preparing the budget and justification. Most require a month's lead time.

Finally you can address areas pertaining to your professional background. Here, there is a need to demonstrate commitment and interest in research. You need to demonstrate that you have access to experts both within and outside the institution who would help develop your skills as a researcher. It is very helpful to have pilot data and some publications to demonstrate your skills and potential as a researcher.

The bulk of your work needs to be completed about three weeks before the deadline for submission. This gives you time to collect necessary administrative signatures, make revisions, and submit the proposal on time.

Grant-application reviewers make their decision based on five criteria: significance of the project, approach, innovation, investigator (the primary concerns here are related to the commitment and perceived potential), and the environment (considerations related to your current training institution and department).

Scores ranging from 100 (excellent) to 500 (poor) are awarded. In addition you get a percentile score that shows how your score compares with that of other similar grant applications submitted in recent rounds. Generally a score of 150 or lower has a good chance of being funded. Successful grants take approximately one year from submission to receipt of funds.

The importance of mentorship in developing a research career cannot be overemphasized. With adequate training, strong commitment, and an excellent proposal, the chances of winning one of the K awards are high. And persistence and desire certainly pay off as well. ■

Evaristo Akerele, M.D., is an assistant professor of clinical psychiatry and co-director of the Addiction Psychiatry Research Fellowship at Columbia University.

Geriatric Psychiatrists Encouraged By New Alzheimer's Drug

Memantine was the "talk of the town" in Baltimore during the 17th Annual Meeting of the AAGP.

BY JIM ROSACK

It was formally the subject of at least four new research poster presentations and one formal industry-supported symposium. But formal presentation or not, memantine (Namenda)—Forest Laboratories' newly launched novel medication for the treatment of Alzheimer's disease (AD)—was the topic to talk about during last month's 17th Annual Meeting of the American Association for Geriatric Psychiatry (AAGP).

The drug came up in numerous informal conversations, symposia sponsored by competing products' manufacturers, and countless other sessions. And it managed to do so without an overly large presence of representatives from Forest—most of the marketing team was said to be busy elsewhere, preparing for the drug's launch the same week as the AAGP meeting.

Simply put, the drug's apparent popularity and seeming importance are based on this simple fact: memantine is the first truly new treatment for patients with Alzheimer's in over a decade. The first of the cholinesterase inhibitors, tacrine (Cognex), debuted in September 1993, followed by three "me too" drugs: donepezil (Aricept) in 1996, rivastigmine (Exelon) in 2000, and galantamine (Reminyl) in 2001.

Memantine, however, is thought to block the N-methyl-D-aspartate (NMDA) receptor, one of two receptors in the brain that normally bind glutamate. The NMDA receptor is thought to mediate certain aspects of learning and memory. As receptor activity increases, those memory processes are inhibited. By blocking NMDA receptor activity, memantine is thought to improve those learning and memory processes.

The FDA approved memantine in October 2003 for the treatment of moderate-to-severe Alzheimer's.

Four studies with memantine were presented as new research posters at the AAGP meeting.

Perhaps the most intriguing was the poster by Elaine Peskind, M.D., and her colleagues. Peskind, a professor of psychiatry at the University of Washington, Seattle, oversaw an industry-funded multicenter, randomized, clinical trial of memantine in patients with mild-to-moderate Alzheimer's. Her results suggest that memantine's ability to significantly delay the decline in cognitive abilities will benefit not only patients with more severe disease, but also those with less-advanced Alzheimer's.

Peskind and her colleagues enrolled 403 patients (both men and women) over the age of 50 with a diagnosis of probable Alzheimer's who had an MRI or CAT scan consistent with probable Alzheimer's and a Mini-Mental State Exam score between 10 and 22. Patients were randomized to memantine 10 mg twice a day or to placebo and followed for 24 weeks.

All patients were given the Alzheimer's Disease Assessment Scale-cognitive subscale (ADAS-cog) and the Clinician's Interview Based Impression of Change-Plus Caregiver Input (CIBIC-Plus). The ADAS-cog, rarely used in the clinical setting, is a standardized clinical trial measure of seven cognitive domains, with a total score ranging from zero to 70. Higher scores denote worse cognitive function. The CIBIC-Plus is an expanded, clinician-rated, interview-based scale similar to the Clinical Global Impression.

Over the course of 24 weeks, those patients taking memantine 10 mg twice a day actually experienced small but significant improvements in cognition, measured by the ADAS-cog, and remained improved compared with baseline at 24 weeks.

In contrast, patients receiving placebo experienced small but significant steady declines in cognitive function over the 24-week study. Peskind and other researchers hope the delay in decline will translate into delaying a patient's institutionalization. A delay in placing an Alzheimer's patient in a nursing home can drastically affect the individual, his or her family, and finances. With average costs of nursing home care running $7,000 a month nationally, even a three-month delay could save a patient $21,000.

Peskind notes that because memantine "has a distinctly novel mechanism of action and very few side effects, it provides physicians, caregivers, and patients a completely

please see ***Alzheimer's*** *on page* 77

Elaine Peskind, M.D., notes that memantine has "a distinctly novel mechanism" that offers "a completely different treatment option" for patients with Alzheimer's disease.

PTSD Program Breaks New Ground in Canada

Canada offers an inpatient treatment program for adults with posttraumatic stress disorder. It is based on the Sanctuary Model developed by Philadelphia psychiatrist Sandra Bloom, M.D.

BY JOAN AREHART-TREICHEL

A Canadian who has posttraumatic stress disorder might be wise to head to Guelph, Ontario. Canada's only inpatient treatment program for PTSD—the "Program for Traumatic Stress Recovery"—can be found there at Homewood Health Center.

The program, which is underwritten by Canada's universal health insurance system, runs six weeks. It has been in existence for a decade and, to date, has treated some 3,000 PTSD patients, from child-abuse survivors and motor-accident victims to peacekeepers who have witnessed atrocities.

Further, as PTSD is being increasingly recognized by health care professionals in Canada, more and more Canadian PTSD patients are being referred to the program. In fact, PTSD patients from other countries are also welcome to participate in it.

The program staff includes psychiatrist David Wright, M.D., family physician and addiction specialist Peter Mezciems, M.D., nurses, psychologists, social workers, occupational therapists, recreation therapists, creative arts therapists, a chaplain, and even a horticultural therapist—altogether some 30 people, a number of whom split their time between the PTSD program and other duties at the Homewood Health Center.

Not surprisingly, medications constitute frontline therapy in the program. "Usually we use the SSRIs plus mood stabilizers, as well as atypical antipsychotics for agitation and paranoid ideation," Wright told *Psychiatric News*. "Many of the patients who come to our program have already tried a lot of medications for their PTSD, so we

please see ***PTSD Program*** *on page 79*

David Wright, M.D.: "We try to create a therapeutic milieu; we talk about safety, safety, safety."

Psychiatrist Says Epidemiology More Than Just Numbers

Funds for psychiatric research, and especially for psychiatric epidemiology research, are limited in Canada. Nonetheless, a psychiatric epidemiologist has chosen to work in Nova Scotia because it offers him something special.

BY JOAN AREHART-TREICHEL

Steve Kisely, M.D., is a 47-year-old, Scottish-born and Australian-educated psychiatric epidemiologist working at Dalhousie University in Halifax, Nova Scotia, Canada. Not long ago, *Psychiatric News* approached him about writing an article on him. "Sure," Kisely replied, "but there is no sense in your interviewing me where I work. I mean, I don't have a flashy lab, just a P.C., routine datasets, and my brainpower—such as it is."

That's how the meeting came to take place in the press room at the annual meeting of the Canadian Psychiatric Association in Halifax, Nova Scotia. Kisely grabbed a cup of coffee, sat down in an easy chair, crossed his legs, and began to discuss his professional life.

Kisely selected Australia for his medical education, he explained, because "I've always had a bit of wanderlust." He decided to become a psychiatrist because "it is one of the few branches of medicine where you view patients as a whole." However, he also became a public health physician as well so that he could work as a psychiatric epidemiologist.

"I've always been interested in dealing with people not just as individuals, but as populations," he said. Yet his ultimate passion, he confessed, is researching psychiatric delivery outcomes—for instance, how well a service is organized, how accessible services are, and how patients fare with a particular service.

Steve Kisely, M.D.: Nova Scotia offers "a fantastic psychiatric service database to work with."

It's About Making a Difference

So what turns him on about psychiatric delivery outcomes research? "Well, it certainly isn't the money!" he chuckled. "I guess it might sound a bit trite, but at the end of the day, it is about making some sort of difference in the quality of life of individuals—to improve their outcome."

He described one example of where he believes his research is making a difference—it involves compulsory outpatient treatment for seriously mentally ill patients. This concept has been introduced throughout the English-speaking world, although there is little scientific evidence that it leads to good outcomes, he said. Back when Kisely was still in Australia (he moved to Nova Scotia a year ago), he and his research colleagues reviewed the few trials that had been conducted on the effectiveness of compulsory outpatient treatment. They found that to avoid one arrest of a mentally ill patient for violence, you would need to treat 500 mentally ill people on a compulsory outpatient basis and that it would take 100 compulsory outpatient orders to prevent one admission.

"This is a blunderbuss treatment, incredibly ineffective," he exclaimed. "The practical implication is that we need adequate community services for the seriously mentally ill, not compulsory outpatient treatment."

Death Rates Higher: Why?

Still another example of where he believes his research is making a difference, he said, is a study he undertook after moving to Nova Scotia. He and his Dalhousie University colleagues compared the death rates of some 67,000 people who received psychiatric treatment in Nova Scotia from 1995 to 2000 with the death rates of the whole population of Nova Scotia during this time.

They found a 50 percent higher death rate for the psychiatric group compared with that for the general population.

"This finding has important public health implications," Kisely declared. "Why is it that so many psychiatric patients are dying? Is it because of side effects of the psychotropic medications they are taking, or because they are socially isolated, or perhaps because they are pursuing different types of lifestyles than psychologically healthy people are? Or could it be due to the fact that they are less likely to receive specialist procedures? Work from Australia suggests that although people with psychological problems are more likely to die of cardiovas-

please see ***Epidemiology*** *on page 63*

Brain Activation May Explain PTSD Flashbacks

PTSD subjects appear to process traumatic memories differently from subjects without PTSD. This difference may help explain why people with PTSD tend to recall traumatic memories as visual flashbacks, while those without the disorder recall verbal narratives.

BY JOAN AREHART-TREICHEL

When persons with posttraumatic stress disorder remember trauma, right areas of their brains tend to be activated, whereas when individuals without PTSD remember trauma, left areas of their brains are apt to be aroused, according to a study reported in the January *American Journal of Psychiatry.*

The study was headed by Ruth Lanius, M.D., Ph.D., an assistant professor of psychiatry at the University of Western Ontario in London, Ontario, and an affiliate of the Robarts Research Institute.

Lanius and her colleagues studied 11 persons who had developed PTSD as a result of sexual abuse/assault or of a motor vehicle accident, and 13 persons who had experienced sexual abuse/assault or a motor vehicle accident but did not develop PTSD as a result. All subjects were right-handed and of similar age, gender, and race.

Each of these subjects was instructed to recall the traumatic event that he or she had experienced. While the subjects were recollecting, the scientists determined which areas of their brains were activated using functional magnetic resonance imaging and functional connectivity analyses. These permit assessment of the activity of a network of neurons across more than one area of the brain.

The investigators found notable differences between the two groups when they compared the results. For example, subjects with PTSD showed more activation in certain right-brain areas—the right posterior cingulate gyrus, the right caudate, the right parietal lobe, and the right occipital lobe. Subjects without PTSD showed more activation in certain left-brain areas—the left superior frontal gyrus, the left anterior cingulated gyrus, the left caudate, the left parietal lobe, and the left insula.

Lanius and her team suspect that this contrasting pattern of brain activation may help explain why PTSD patients tend to experience traumatic recall as flashbacks (spontaneous, vivid, usually visual memories unchanging over time) and why non-PTSD individuals are more apt to experience traumatic memories as verbal narratives.

For example, the right parietal lobe is known to be involved in the nonverbal memory retrieval of events in people's lives, so its activation while persons with PTSD are remembering distressing events may very well help explain why they recall these events as flashbacks. In contrast, the left brain areas activated by non-PTSD individuals when they recollect disturbing events are consistent with verbal episodic memory retrieval and may help explain why they remember such events as verbal narratives.

"This is a fantastically interesting study," Bessel van der Kolk, M.D., a professor of psychiatry at Boston University and medical director of the Trauma Center there, said in an interview. "Dr. Lanius has elegantly demonstrated how people's brain function differs when they are in dissociate states. . . . We always suspected that when people go into these states, there is a decrease in activation of the left inferior prefrontal cortex—meaning that people are less capable of taking in new information and being curious about the world out there—and that the brain shifts to a more right posterior activation—more to a state of fear and flight."

Dutch scientists have also just published findings very similar to those of Lanius and her colleagues, van der Kolk pointed out, which gives added legitimacy to the findings of Lanius and her team.

Van der Kolk said that he was pleased to see such studies being pursued by Canadian and European scientists.

The study was financed by the Canadian Institutes of Health Research and the Ontario Mental Health Foundation.

The study, "The Nature of Traumatic Memories: A 4-T fMRI Functional Connectivity Analysis," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/1/36?>. ■

Annual Meeting

Tour New York The Easy Way

APA members coming to New York City for APA's 2004 annual meeting in May can leave the driving to someone else if they want to explore this grand city. APA has arranged a series of tours that will show off many facets of the city, from the well known to the obscure but nonetheless interesting. Many will be offered twice during the week of the meeting. To obtain a schedule and description of the tours or to register, go to the Web site <www.eventtrans.com/apatours04.htm>. The deadline for advance reservations is **April 5.** Members can pick up reserved tickets at the on-site Tour Desk, located in the Javits Center lobby.

Why Are We Taken In By Duplicity?

A psychiatrist takes a psychoanalytic view of the reasons so many people seem vulnerable to the machinations of hypocrites.

BY JOAN AREHART-TREICHEL

Why do so many people fall for scams, unproven medical treatments, sexual seduction, empty political promises? In short, why do so many people fall prey to hypocrisy, which for the purposes of a presentation at the recent meeting of the American Psychoanalytic Association was defined as "consciously intended deception by a person in a position of trust"?

It may be because they can't stand uncertainty, idealize the hypocrite, have strong desires for something, and transfer their childhood-acquired trust to the hypocrite.

So suggested Anton Kris, M.D., a clinical professor of psychiatry at Harvard Medical School, during a plenary talk at the meeting, held in New York City in January. His talk was titled "The Lure of Hypocrisy."

Some 20 years ago, Kris reported, he started pondering why people are taken in by hypocrites. He came to the conclusion that one of the major reasons is that people idealize figures of authority such as their bosses, religious or government leaders, or those in the healing professions.

But idealization alone will not lead a person to being vulnerable to duplicity, he said; it must also be accompanied by anxiety.

"It seemed to me that idealization as a defense against the dread of uncertainty accounted for the susceptibility to hypocrisy," he explained. "That is, the desire for certainty leads to idealization of the hypocrite in exchange for the individual's credulity."

Yet even when idealization and the yearning for certainty are present, he continued, they will not bring about susceptibility to hypocrisy unless they are also accompanied by strong desires to obtain something. For instance, he said, "Terminally ill patients and their families may yield to wishful fantasy in their search for 'miracle' cures, [and] under those circumstances, they become vulnerable to hypocritical snake-oil hucksters."

And yet a fourth ingredient is also necessary if people are going to fall prey to hypocrisy, he asserted—"credulity resulting from a transference-based, developmentally early form of trust." All in all, he concluded, "It remains a difficult task throughout life to maintain a balance between trust and distrust."

But surely many people are impervious to hypocrisy? Kris thinks not. "*Everyone* is susceptible to hypocrisy under *some* circumstances," he cautioned. "In times or conditions of increased uncertainty, that susceptibility will be particularly great." ■

Harassment Hits Close to Home For Mentally Ill

The stigma of mental illness is manifested in numerous ways, including harassment—even by family members.

BY JOAN AREHART-TREICHEL

There is an old English saying, "Sticks and stones may break my bones, but words can never harm me."

That saying does not seem to apply to persons who are mentally ill, suggests a study conducted in Scotland and reported in the December *British Journal of Psychiatry*.

University of Glasgow investigators interviewed 330 Scots—half of whom had serious mental health problems and half of whom did not—about experiences they had had with harassment. Harassment was defined as being mocked, bullied, physically threatened, or even physically assaulted.

Forty-four percent of the control group had been harassed at some point, compared with 60 percent of the group with mental illness—a highly significant difference statistically. What's more, while only half of the 44 percent said that the provocation had had a negative impact on their mental health, nearly all of the 60 percent reported having felt a negative impact, especially when the harassment was directed at their mental states.

For instance, one mentally ill woman said that as a result of people pestering her, "I ended up in hospital virtually every month, and my condition became worse." Said another, "I actually sat in front of the TV one night with a rolling pin and a knife because I was worried they would get in and try and hurt me."

Also, while the mentally healthy group was found to experience most of their badgering in the workplace, the mentally ill group was found to experience most of theirs in the community by teens and neighbors. Sometimes the subjects with mental illness were even verbally abused by their own family members, the researchers discovered. This finding surprised them. Said one mentally ill man in Dundee, Scotland, "I had ECT treatment for depression, and members of my family, especially my sister, think it's funny.

please see ***Harassment*** *on page 64*

Depression Care Compromised By Lack of Follow-Up

In 1999 almost 59 percent of adults diagnosed with a new episode of depression received a continuous trial of antidepressants through the acute phase of treatment, but in 2001 that dipped to less than 57 percent.

BY MARK MORAN

Only about 20 percent of patients prescribed a medication to treat depression have at least three recommended follow-up visits to monitor their medication in the 12 weeks after diagnosis.

Moreover, half of the people with depression stop using their medication within the first month.

Those were among the findings from the "National Healthcare Quality Report," issued by the federal Agency for Healthcare Quality and Research last December. The report was accompanied by the "National Healthcare Disparities Report." Together, the two reports document the quality of American health care and the differences in use of services across the population.

The reports presented data on the quality of, and differences in the access to, services for seven clinical conditions, including depression. The other conditions were cancer, diabetes, end-stage renal disease, heart disease, HIV and AIDS, and respiratory disease. The reports also included data on maternal and child health, nursing home and home health care, and patient safety.

"Limited progress is being made in quality of medication treatment [for depression]," the AHQR stated. "About 60 percent of depressed patients do not receive the acute-phase treatment they need, and about 40 percent do not receive the continuous-phase treatment they should have. Moreover, these rates have not improved over the three-year period that these measures were tracked (1998, 1999, and 2001; data were not available in 2000)."

The report found that in 1999, almost 59 percent of adults diagnosed with a new episode of depression received a continuous trial of antidepressants through the acute phase of treatment, but in 2001 that dropped to less than 57 percent. The percentage of adults who remained on antidepressants through the continuation phase of treatment dropped from 42 percent in 1999 to 40 percent in 2001.

The AHQR used three measures to determine quality of depression treatment:

- Percent of adults who had at least three follow-up office visits with a primary care or mental health provider in the 12-week, acute-treatment phase after a diagnosis of depression and prescription of antidepressant medication.
- Percent of those adults who received a continuous trial of medication treatment during the acute-treatment phase, defined as the period immediately after a new episode.
- Percent of adults who were diagnosed with a new episode of depression, started on an antidepressant drug, and remained on medication through the continuation phase, defined as the six months following initial diagnosis and treatment.

The "National Healthcare Quality Report" and the "National Healthcare Disparities Report" are posted online at <www.qualitytools.ahrq.gov>. ■

Epidemiology

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cular disease, they are less likely to have received revascularization or coronary artery bypass grafts."

Kisely plans to continue studying psychiatric service outcomes. "It taps into my interest as a psychiatrist and as an epidemiologist," he observed. "All things being equal, I will not change."

Lured by Databases

Why did he leave balmy Perth, Australia, to move to wet, cold Halifax, Nova Scotia?

"Well," he avowed, "there isn't a lot of research money in Canada these days. What's more, the psychiatric research budget in Canada was slashed especially dramatically this year. Before, one-third of research grant applications were funded; now it's only one-fifth. Also, psychiatric epidemiologists in Canada are in even poorer straits financially than are other kinds of psychiatric scientists because, frankly, our kind of work is not glamorous and high tech, and because people find it hard to get enthused about databases.

"On the other hand, the financial situation for psychiatric researchers in Australia these days isn't any rosier than that for psychiatric researchers in Canada. What's more, my Dalhousie colleagues and I are getting a lot of mileage out of the little research money we receive.

"And Nova Scotia offers me something that I would be hard-pressed to find in other areas of Canada, or even in Australia, for that matter—a fantastic psychiatric services database to work with. Inpatient visits, outpatient visits, community visits, and prescription-drug information for the entire province are all documented and easily and accessible." ■

Study Opens Way for Treatments Aimed at Recovery

While schizophrenia is a chronic illness, a number of schizophrenia patients do improve over time. Nonetheless, the prospects of a full recovery are limited.

BY JOAN AREHART-TREICHEL

During the past few years, there has been increasing reason to believe that some persons with schizophrenia can recover—that is, cross the bridge from the world of voices, delusions, and bizarre behavior into one that is, if not ideal, at least less traumatic and more conventional.

Take the case of scientist John Nash depicted in the book *A Beautiful Mind* and a movie by that same title. Or Frederick Frese, Ph.D., who had schizophrenia and who today is a psychologist and vice president of the National Alliance for the Mentally Ill (*Psychiatric News*, August 1, 2003). Or two follow-up studies—one published in 1988 and the other in 2001—that found that about half of schizophrenia patients eventually recover or have only mild impairments.

But what is the more immediate prognosis for young persons who have experienced a first episode of schizophrenia? Good for some but unfortunately not for most, a new study suggests. It was headed by Delbert Robinson, M.D., a research psychiatrist at Zucker Hillside Hospital in Glen Oaks, N.Y., and was published in the March *American Journal of Psychiatry*.

Although two investigations have been undertaken into the long-term prognosis for schizophrenia patients, as mentioned above, Robinson's appears to be the first to assess recovery in young persons with schizophrenia.

They recruited 118 young people whose average age was 25 and who had developed schizophrenia or schizoaffective disorder. They treated the subjects over the next five years and then assessed them, at baseline and periodically during the five-year period, for the presence of illness symptoms and to determine how well they were functioning socially and vocationally.

For instance, the researchers determined whether subjects were neat, clean, and appropriately dressed; performing day-to-day tasks without supervision; holding a paying job, attending school at least part time, or performing a homemaker role adequately; and interacting with a friend or romantic contact at least once a week.

At the end of the five years, the researchers found, half of the subjects had achieved remission of positive and negative symptoms for at least two years; a quarter of their subjects had achieved sustained, adequate vocational and social functioning; and about one-eighth met full recovery criteria for two years or more. While many subjects had stopped medication at some point during the study, long-term medication adherence was very high.

So, "although some patients with first-episode schizophrenia can achieve sustained symptomatic and functional recovery," the scientists concluded, "the overall rate of recovery during the early years of the illness is low."

Though only a minority of subjects in this study achieved full recovery, two other scientists studying schizophrenia recovery—Alex Kopelwicz, M.D., and Robert Liberman, M.D., of the University of California at Los Angeles—said in an e-mail to *Psychiatric News*, "This study's findings should put to rest the nihilistic but too-often-held view that schizophrenia necessarily runs a chronic, deteriorative course. Most important, by using clearly articulated, operational definitions of recovery, this study should open the way for future research aimed at developing treatments that promote recovery from schizophrenia."

In fact, Robinson and his colleagues scrutinized their data to see if they could identify some of the factors that give young persons with schizophrenia a "leg up" toward recovery. They found, for example, that young people with a schizoaffective disorder appear to have a particularly good prospect of symptom remission. Young people who have either schizophrenia or schizoaffective disorder and fairly good cognitive functioning at stabilization have a good chance of making a full recovery. And a shorter duration of psychosis before treatment appears to predict both symptom remission and full recovery.

The study was funded by the National Institutes of Health.

The study report, "Symptomatic and Functional Recovery From a First Episode of Schizophrenia or Schizoaffective Disorder," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/3/473?>. ■

Harassment

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She calls me 'Sparky.' I find it very hurtful, and I've tried to talk with her about it, but she keeps on doing it anyway."

Subjects were asked what they thought would stop harassment. The consensus among both groups was that education to make the public aware of how much maliciousness hurts people, especially those who are already in a fragile mental state, would do the most good.

An abstract of the study, "Prevalence and Experience of Harassment of People With Mental Health Problems Living in the Community," is posted online at <http://bjp.rcpsych.org/cgi/content/abstract/183/6/526>. ■

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Cardiovascular Risk Elevated In Depressed Older Women

In addition to interfering with one's quality of life, depressive symptoms may have far more serious consequences for postmenopausal women.

BY EVE BENDER

Postmenopausal women who experience symptoms of depression have a 50 percent greater chance of developing or dying from cardiovascular disease than women without depression symptoms, according to a report in the February 9 *Archives of Internal Medicine*.

Researchers found that among a sample of more than 93,000 postmenopausal women enrolled in the Women's Health Initiative Observational Study, 15.8 percent scored positive for depressive symptoms. Symptoms were determined with six items from the Center for Epidemiological Studies Depression Scale and two from the Diagnostic Interview Schedule. Women who previously had been diagnosed with mental illness were excluded from the study.

The Women's Health Initiative is a long-term study designed to identify and explore a number of environmental and biological factors and their relation to health problems, such as heart disease, cancer, and osteoporosis, in older women.

Sylvia Wassertheil-Smoller, Ph.D., and colleagues investigated the link between depressive symptoms and cardiovascular problems, including heart attack and stroke, in 93,676 women aged 50 to 79 years who enrolled in the study between September 1993 and December 1998.

Researchers followed the women for an average of four years.

Wassertheil-Smoller is principal investigator of the Women's Health Initiative at the New York Clinical Center and a professor of epidemiology and population health at the Albert Einstein College of Medicine in New York City.

When she analyzed the association between cardiovascular problems and depressive symptoms, she found that among women who reported having no lifetime history of cardiovascular disease at the baseline assessment, depressive symptoms were associated with a 58 percent greater risk of death from cardiovascular disease than in women without the symptoms.

Differences in risk of cardiovascular death between women with depressive symptoms and those without the symptoms were noted six months after the baseline assessment, according to the study.

After adjusting for a variety of health and lifestyle factors, such as diabetes, smoking, body mass index, and physical activity, the risk still remained high—women had a 50 percent greater risk of developing or dying from cardiovascular disease than women without depressive symptoms.

In addition, Wassertheil-Smoller found that women with depressive symptoms were 12 percent more likely to have hypertension and 60 percent more likely to have a history of stroke or angina.

Although other studies have found that subclinical depressive symptoms may be a risk factor for cardiovascular-related death, Wassertheil-Smoller pointed out that her study examined these risks in the largest sample of postmenopausal women to date.

The exact nature of the link between depressive symptoms and heart disease is unknown, she told *Psychiatric News*.

"We need a better handle on the mechanism through which this is operating. Is subclinical depression a prodrome to cardiovascular illness or does it actually play a role in the development of cardiovascular disease?" she asked.

She said she hopes one day to be able to analyze blood samples taken from subjects enrolled in the Women's Health Initiative "to see whether we can identify biomarkers associated with both depression and cardiovascular events."

In addition, she said, clinical trials are needed to test whether early identification and treatment of women with subclinical depression will lower risk of developing or dying from cardiovascular disease.

An abstract of the study, "Depression and Cardiovascular Sequelae in Postmenopausal Women," is posted online at <http://archinte.ama-assn.org/cgi/content/abstract/164/3/289>. ■

Nominations Invited

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.

Nominations for the 2005 award postmarked on or before June 30 will be accepted. 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.

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. ■

Psychosis Has Minimal Impact on Neurocognition

Delaying treatment for psychosis doesn't seem to have negative effects on a person's ability to learn, remember, and otherwise engage in neuropsychological processes.

BY JOAN AREHART-TREICHEL

From a common-sense perspective, one would expect psychosis to wreck havoc with a person's efforts to learn, remember, react, and otherwise use his or her brain. One might also expect that putting off treatment for psychosis would have a baleful effect on neurocognition as well.

Intuition, however, may not always be right, a new study reported in the March *American Journal of Psychiatry* suggests. It has found no adverse neurocognitive effects either from psychosis or from delaying treatment for it.

The study was conducted by Björn Rund, Ph.D., a psychologist at the University of Oslo in Norway, other Norwegian investigators, and Thomas McGlashan, M.D., a professor of psychiatry at Yale University.

The investigation included 207 Norwegian subjects who were diagnosed for the first time with schizophrenia, schizophreniform disorder, schizoaffective disorder, brief psychotic episode, delusional disorder, affective psychosis with mood incongruent delusions, or psychotic disorder not otherwise specified.

The subjects were assessed for symptoms three months after starting treatment. The subjects were also given neuropsychological tests after they were stabilized or experienced symptom remission, which was, on average, about three months after starting treatment. The neuropsychological tests evaluated verbal learning, working memory, motor speed, and executive function. They included, for example, the California Verbal Learning Test, the Finger-Tapping Test, and the Wisconsin Card-Sorting Test.

The researchers then attempted to see whether there were significant links between the subjects' psychotic symptoms at three months after starting treatment and their neuropsychological test results at stabilization or remission, which was, on average, also three months after starting treatment.

They found neither, suggesting that psychosis had little impact on neurocognition. And even when the investigators looked only at subjects who were not experiencing remission from their psychotic symptoms at the time of neuropsychological testing, which was 43 percent of subjects, they still could find no strong connections between psychosis and neurocognition.

Thus psychosis appears to have minimal impact on neurocognition, they concluded.

The investigators then looked for a significant link between duration of untreated psychosis in the subjects—that is, the time from onset of psychotic symptoms to the start of adequate treatment for psychosis—and the subjects' neuropsychological test scores at the time of stabilization or remission. They again failed to find a link, implying that putting off treatment for psychosis does not damage neurocognition.

A similar result has been obtained by other researchers—for instance, Beng-Choon Ho, M.D., clinical director of the University of Iowa Schizophrenia Research Center, and coworkers (*Psychiatric News*, January 7, 2003). Some other scientists, however, have found the opposite—for example, Delbert Robinson, M.D., a research psychiatrist with Zucker Hillside Hospital in Glen Oaks, N.Y., and colleagues (see page 64).

So why have some researchers found that delaying treatment for psychosis does not hurt neurocognition, whereas others have found the opposite? One possibility, Robinson told *Psychiatric News*, is that the biological underpinnings of persons with first-episode schizophrenia or schizoaffective disorder differ from the biological underpinnings of persons with other types of first-episode psychosis. As a result, delaying psychosis treatment might impair neurocognition in the former group, but not in the latter.

The study was funded by the Norwegian Research Council, the National Council for Mental Health/Health and Rehabilitation, the National Institute of Mental Health, the Norwegian Health Ministry, and the Theodore and Vada Stanley Foundation.

The study, "Neurocognitive Dsyfunction in First-Episode Psychosis: Correlates With Symptoms, Premorbid Adjustment, and Duration of Untreated Psychosis," is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/161/3/466>. ■

ODYSSEY SURMONTIL

P4C

med check

COMPILED BY JIM ROSACK

Regulatory and Legal Briefs

• ***Modafinil*** was approved by the U.S. Food and Drug Administration (FDA) for the improvement of wakefulness in patients with excessive sleepiness associated with obstructive sleep apnea or shift-work sleep disorder.

Cephalon, which markets the atypical stimulant under the brand name Provigil, had requested approval for the treatment of all sleep disorders. The agency, however, agreed with of its advisory panel, which had recommended a more narrow indication due to concern that such a broad indication could lead to overprescribing.

The most frequent treatment-emergent adverse events associated with modafinil are headache, nausea, nervousness, stuffy nose, diarrhea, back pain, anxiety, and difficulty in sleeping.

• ***Olanzapine*** became the second medication approved by the FDA for the treatment of bipolar disorder. Lithium, approved in 1974, is the only other medication that carries an indication for both bipolar depression and bipolar mania, although many medications are now indicated for the acute treatment of mania alone. Olanzapine gained its mania indication in 2000.

In multiple randomized, placebo-controlled trials for both schizophrenia and bipolar disorder, the most frequent adverse events associated with olanzapine were drowsiness, dizziness, weight gain, dry mouth, constipation, restlessness, low blood pressure, and weakness. Hyperglycemia, in some cases associated with ketoacidosis, coma, or death, has been reported in patients treated with second-generation antipsychotic medications, including olanzapine.

• ***Quetiapine*** was approved by the FDA both as a monotherapy and as adjunct therapy with lithium or divalproex for the short-term treatment of acute manic episodes associated with bipolar I disorder. A pooled analysis from two double-blind, placebo-controlled trials showed efficacy and safety in treating acute mania in doses up to 800 mg per day as monotherapy, and a separate analysis of trial data showed efficacy as an adjunct to the two mood stabilizers. The most frequent side effects associated with quetiapine were somnolence, dizziness, dry mouth, constipation, increases in liver enzymes (of unknown clinical significance), and weight gain.

• All patients under the age of 18 taking ***SSRIs*** have been urged by Health Canada to contact their prescribing physicians "to confirm that the benefits of the drug still outweigh its potential risks in light of recent safety concerns." The public health advisory follows hearings in the United States on the potential association of SSRIs with suicidal/self-harming behaviors (see page 2).

Research Briefs

• ***Benzodiazepine*** use can be curtailed with a structured, time-limited intervention in older patients taking the medications for chronic insomnia. In a study of 76 patients with long-term insomnia and medication use, 85 percent of patients who underwent a structured medication taper plus cognitive-behavioral therapy were medication free at seven weeks, compared with 48 percent of those who underwent the same medication taper but did not receive the structured CBT. While CBT appears to alleviate the insomnia, the authors noted, real sleep improvements may not be apparent until several months following benzodiazepine withdrawal.
Am J Psychiatry 2004; 161:332-342

• ***Venlafaxine*** may be effective for children and adolescents who have ADHD but not comorbid depression. In a small, controlled study, the combined norepinephrine/serotonin reuptake inhibitor was associated with significant reductions in total scores on the Conners parent scale and the Clinical Global Impression severity item after a six-week trial. Treatment-emergent adverse events included gastrointestinal upset, somnolence, and headache, but they were generally transient.
Psychiatry Clin Neurosci 2004; 58:92-95

Medication Names and Manufacturers

The following medications appear in this edition of Med Check:

- **Asenapine:** under development (Organon/Pfizer)
- **Atomoxetine:** Strattera (Eli Lilly & Co.)
- **Bupropion:** Wellbutrin/Wellbutrin XL (GlaxoSmithKline)
- **Chlorpromazine:** Thorazine (GSK); generics
- **Clozapine:** Clozaril (Novartis); generics
- **Divalproex:** Depakote/Depakote ER (Abbott Laboratories); generics
- **Donepezil:** Aricept (Eisai/Pfizer)
- **Fluphenazine:** Prolixin (Apothecon); generics
- **Gaboxadol:** under development (Lundbeck/Merck)
- **Haloperidol:** Haldol (McNeil); generics
- **Lithium:** Lithobid (Solvay); Eskalith (GSK); generics
- **Modafinil:** Provigil (Cephalon)
- **Olanzapine:** Zyprexa (Lilly)
- **Olanzapine (for injection):** Zyprexa IntraMuscular (Lilly; pending FDA approval)
- **Paroxetine hydrochloride:** Paxil/Paxil CR (GSK)
- **Paroxetine mesylate:** Pexeva (Synthon; available mid-2004)
- **Quetiapine:** Seroquel (AstraZeneca)
- **Risperidone:** Risperdal/Risperdal Consta (Janssen)
- **Venlafaxine:** Effexor/Effexor-XR (Wyeth)
- **Zaleplon:** Sonota (Wyeth)

• Tapering of ***atomoxetine*** therapy does not appear to be necessary. The medication is not associated with a risk of an exaggerated symptom rebound or adverse events when patients abruptly stop their medication. Effects of abrupt discontinuation were studied in four large clinical trials in both children and adults with ADHD. After nine weeks of continuous therapy with the norepinephrine reuptake inhibitor, abrupt discontinuation, as expected, was followed by a general worsening of symptoms, but not to the pretreatment level. No statistically significant discontinuation-emergent adverse events were found in the study subjects compared with patients taking (and abruptly discontinuing) placebo.
J Clin Psychopharmacol 2004; 24:30-35

• ***Bupropion*** may be a safe and effective treatment for adolescents with nicotine dependence and comorbid ADHD. In an open-label pilot study with 16 adolescents who smoked, 11 also had ADHD. All of the subjects were titrated to bupropion SR 150 mg twice a day and maintained for six weeks. They also received two brief smoking-cessation counseling sessions.

After four weeks, 31 percent of the study participants were abstinent, and the remainder experienced significant reductions in the number of cigarettes smoked daily. Bupropion, a weak inhibitor of norepinephrine, serotonin, and dopamine, did not appear to worsen the patients' ADHD symptoms.
J Am Acad Child Adolesc Psychiatry 2004; 43:199-205

• ***Paroxetine*** and other SSRIs are associated with hyponatremia in elderly patients. In a prospective, longitudinal study involving 75 seniors who had depression and were treated with paroxetine, 12 percent developed clinically significant hyponatremia within 10 days of beginning SSRI therapy. Lower body mass and lower baseline sodium levels appeared to be significant risk factors for development of hyponatremia.

Symptoms of decreased serum sodium are often mild and nonspecific, including anorexia, fatigue, lethargy, and confusion—all common in elderly patients with depression and likely to be overlooked. Significant, untreated hyponatremia, however, may be fatal.

Researchers suspect enhanced serotonergic tone leads to increased secretion of the hormone ADH. As blood volume increases due to decreased diuresis, sodium concentration falls. Baseline and periodic electrolyte monitoring is recommended.
Arch Intern Med 2004; 164:327-332

• ***Antipsychotics*** and ***antidepressants*** with significant anticholinergic activity can lead to a pattern of cognitive impairment involving decreased complex attention, declarative memory, and auditory and visual memory not related to a patient's primary mental disorder. Anticholinergic load does not appear to affect intelligence, simple attention, working memory, executive functions, or motor speed. Researchers estimate that as much as one-third to two-thirds of the memory deficit typically seen in patients with schizophrenia is due to anticholinergic load and can be alleviated by better medication management.
Am J Psychiatry 2004; 161:116-124

• Not all ***antipsychotics*** are created equal, especially in their risk of causing abnormalities in glucose metabolism, including diabetes. A new study screened peer-reviewed publications, as well as oral and poster presentations. Confirming previous reports *(Psychiatric News*, March 5), Dutch researchers found 27 case reports of treatment-emergent diabetes associated with clozapine, 39 for olanzapine, four for risperidone, and three for quetiapine between 1995 and 2001 in 13 Western countries, Brazil, and Japan. In the majority of cases, risk factors such as family history, obesity, and ethnicity were present in patients developing diabetes while on an antipsychotic. The researchers noted that a slight overrepresentation of cases associated with olanzapine and clozapine may be reported, related to their longer duration on the market. Careful monitoring of weight, body mass index, and glucose levels is advised.
Pharmacopsychiatry 2004; 37:1-11

• ***Risperidone*** is more effective than haloperidol at improving negative symptoms in patients with schizophrenia. The two drugs, however, are comparable on improving positive symptoms and total rating-scale scores.

A study was conducted of 41 patients with schizophrenia who took either risperidone (1 mg to 12 mg) or haloperidol (2 mg to 20 mg) daily for three months. Tolerability of risperidone was statistically significantly better than haloperidol as well. The most frequent treatment-emergent adverse events for both drugs were tremor and rigidity; however, they were more pronounced in patients taking haloperidol. Serum prolactin levels, elevated in both groups, were the best predictor of extrapyramidal side effects.
Prog Neuropsychopharmacol Biol Psychiatry 2004; 28:285-290

• ***Risperidone–long-acting injection*** appears to be beneficial for only about half of the patients who received the new long-acting, second-generation antipsychotic. In a case series report of 50 patients followed over six months, 54 percent achieved at least minimal improvement, 4 percent remained unchanged, 24 percent failed to comply with the injection regimen, and 18 percent deteriorated and were switched to alternative antipsychotic medications. Attrition rate at six months was 42 percent. Supplementation with oral medication was often required for longer than three weeks.
Psychiatr Bull R Coll Psychiatr 2004; 28:12-14

• ***Antipsychotic polypharmacy*** is generally not thought to be safe and effective, and evidence continues to back up that clinical assumption. A case review of 25 patients (18 inpatients and seven outpatients) with

please see ***Med Check*** *on page 74*

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schizophrenia who had been treated with high-dose polypharmacy without improvement examined the effect of switching patients to a single second-generation medication at optimal dosing.

Patients were followed for 12 weeks after the switch. Eleven of the 18 inpatients improved enough on second-generation monotherapy to be discharged, while four were close to discharge at 12 weeks. Average antipsychotic dose was reduced from 2203 mg (chlorpromazine equivalents) to 619 mg per day. The average number of antipsychotic medications decreased from 3.5 to 1.1, while the overall number of psychotropic medications was reduced from nearly seven to 2.6.

Prog Neuropsychopharmacol Biol Psychiatry 2004; 28:361-369

• ***Olanzapine*** provides significantly more improvement than fluphenazine for long-term treatment of patients with schizophrenia. A 22-week, double-blind, parallel trial compared the two drugs with multiple rating measures for safety and efficacy. Patients taking olanzapine showed greater improvement from baseline to endpoint on the Brief Psychiatric Rating Scale score, the Positive and Negative Syndrome Scale total and positive scores, and the Clinical Global Impression severity score. In addition, patients taking olanzapine showed greater decreases in extrapyramidal side effects compared with patients taking fluphenazine. Weight gain was the most frequent treatment-emergent adverse event in the olanzapine group, while akathisia and insomnia were most common in those taking fluphenazine.

Prog Neuropsychopharmacol Biol Psychiatry 2004; 28:311-318

Industry Briefs

• ***Risperidone–long-acting injection*** is reportedly a safe and effective alternative for young adults with schizophrenia who are stable on their oral antipsychotic medication. In a presentation at the 12th Biennial Winter Workshop on Schizophrenia in Davos, Switzerland, Professor Hans-Juergen Moller from Ludwig-Maximilians-Universität in Münich reported preliminary data from the Switch to Risperidone Microspheres (StoRMi) clinical trial. These data conflict with a British report (above) in which only half of patients improved.

Nearly 120 young adults aged 18 to 30 were switched from their oral medication to the long-acting risperidone in the German study. More than half had been taking oral new-generation antipsychotics, while 28 percent were on a first-generation medication. Both positive and negative symptoms improved significantly for the majority of patients within the first month and continued to improve over six months.

• Danish neuropsychopharm giant Lundbeck A/S and Merck and Co. announced an agreement to develop and commercialize ***gaboxadol*** in the U.S. market. Gaboxadol is a novel, direct-acting GABA-A receptor agonist currently in Phase III clinical trials for the treatment of sleep disorders. To date, the compound has shown sleep-inducing as well as sleep-maintaining properties that have resulted in improvements such that sleep patterns appear to normalize. Under the agreement, Lundbeck will co-promote gaboxadol to psychiatrists following introduction to the U.S. market, which is thought to be at least 18 to 24 months away.

• Akzo-Nobel's Organon unit has announced that it is continuing its collaboration with Pfizer on the development and commercialization of ***asenapine,*** a 5HT2/D2 antagonist. The new-generation antipsychotic is in Phase III trials for the treatment of schizophrenia and bipolar disorder. Early clinical data suggest that asenapine is well tolerated and shows statistically superior efficacy when compared with placebo.

• An extended-release formulation of ***zaleplon*** is under development for the treatment of insomnia by King Pharmaceuticals. A Phase II clinical trial program will begin by the end of April, designed to select the most effective extended-release formulation of the short-acting, nonbenzodiazepine hypnotic. The immediate-release formulation of zaleplon is effective in patients who experience difficulty in onset of sleep; however, it has not been shown to increase total sleep time or reduce the potential for premature awakening. In clinical trials to date, the most frequent treatment-emergent adverse events associated with zaleplon were headache, dizziness, and somnolence.

• A rapidly dissolving form of ***donepezil*** could make administering that medication to patients with Alzheimer's disease easier, contributing to improved compliance. A Supplemental New Drug Application was filed by Eisai/Pfizer in Japan nearly a year ago and has now been filed in the U.S. and the European Union through its mutual-recognition procedure. The FDA is expected to make a preliminary decision on the application by late 2004 or the first quarter of 2005. ■

Annual Meeting

APA, Members Beat Back Bullying

Leading a group discussion about bullies and bullying for young sexual offenders in a residential treatment center, I offered several examples of how bullying isn't confined to schools or the streets. The December 19, 2003, issue is full of exemplary instances of how APA and individual members have successfully fought bullying by the insurance industry, licensing boards, and even large medical centers (in the case of Fletcher Allen in Burlington, Vt., attempting to "carve out" a mental health unit separate from the rest of the hospital). The Assembly rightly honored Drs. Harold Eist and Daniel Shrager for their courage and tenacity in defending patient confidentiality. And Dr. Marcia Goin's leadership in joining with New York psychiatrists and the New York State Psychiatric Association to beat back an intrusive and inappropriate audit process of patient records by Oxford Insurance Co. is yet another powerful response to "boardroom bullying" of our patients and our profession.

A former APA president, Dr. Herbert Sacks, once challenged members to think about their answer to "What did you do in the war, Dad?" Many of our colleagues continue to ask the question "What has APA done for me recently?" The above examples, as well as many other acts of courage by APA members that may never make it into *Psychiatric News*, give us a lot to be proud of. I'll keep the December 19 issue to show to skeptics.

JAMES H. MAIER, M.D.
Scarborough, Maine

New Drug Combination

I believe that *Psychiatric News* crossed the line in the December 19, 2003, issue from news to advertising in its enthusiastic article about OFC, the Eli Lilly product that the FDA is expected to approve soon.

There is no doubt that an olanzapine-fluoxetine combination therapy is useful for many patients. However, combining the two medications in one pill appears to be a marketing technique, not an advance in patient care. Currently, we practicing psychiatrists can choose from a variety of olanzapine and fluoxetine dosage strengths and adjust each separately as needed for patient benefit. With the advent of generic fluoxetine this past year, self-pay patients and third-party payers alike have saved large amounts of money on patients who take this medication. And with more competition in the antipsychotic arena, even the cost of olanzapine has, thank goodness, decreased somewhat.

OFC does not appear to come in a great variety of dosage combinations (just three were mentioned in one of the Web abstracts). Additionally, neither the article nor the abstracts made any mention of cost. Thus, unless each combination is less expensive than two separate prescriptions for brand-name Zyprexa and generic fluoxetine, OFC will just be one more expensive, unnecessary drug in the marketplace.

RICHARD WINSLOW, M.D.
Mercer Island, Wash.

Editor's note: In view of the issues that Dr. Winslow raised, we contacted Eli Lilly and were given the following information: Symbyax is available in four strengths (mg olanzapine/mg fluoxetine): 6/25, 6/50, 12/25, and 12/50. The pricing of Symbyax is comparable, based on dosing, to Zyprexa alone. There is no additional cost for the fluoxetine component. Thus, the dosages with 6 mg of olanzapine will be priced similarly to 5 mg of Zyprexa, and 12 mg of olanzapine will be priced between 10 mg and 15 mg of Zyprexa.

Mentor System

Many psychiatry residency programs are working on increasing cohesion between residents, as well as between residents and faculty members, in addition to encouraging progressive thinking within the department. Others are looking for methods to elevate residents' morale and to infuse positive energy into residency training. I believe cohesion, high morale, and positive energy are not separate or separable goals. Each reinforces the other, so serving any one requires an integrated way that serves all three.

I suggest a mentor system that may help us achieve our common goals. In this system, residents and attendings are divided into teams. Each team consists of one resident from each class, a psychiatry attending, and a psychology attending. By doing this, we will have teams of five to six members, with the attendings acting as mentors to residents, and senior residents guiding junior residents in a friendly way.

Some of the benefits of this method are to increase cohesion and team work between residents of different classes and attendings, provide multiple and diverse levels of mentoring and cooperation, and enable teams to use units that can start their own projects or activities or the department's projects or activities, help new residents move and adapt to the city and to the program, facilitate transition from one year to anther, provide help and support to struggling residents, and encourage the ones who are doing well.

MOHAMED RAMADAN, M.D.
Wichita, Kan.

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.

SSRIs

continued from page 2

study 329, five patients on the drug attempted suicide, while none did on placebo. Although a risk ratio cannot be calculated due to division by zero, the suicide attempts are elevated relative to placebo.

For study 329, the conclusion is obvious: based on the data from 329 alone, paroxetine is associated with an elevated risk of suicidal thoughts and behaviors. But not so fast. When FDA and United Kingdom regulators looked at the other two studies, the picture became muddy all over again. In both study 377 and 701, the risk of a suicide-related event or attempt was nearly equal for both the active-drug group and placebo—a risk ratio very close to 1.0.

Regulators in the United Kingdom called the data in study 329 a "signal" of increased risk and issued strongly worded warnings not to prescribe paroxetine to anyone under 18—that in light of little or no evidence that paroxetine had any efficacy in child and adolescent depression, the risk outweighed any potential benefit.

Meanwhile, on this side of the big pond, FDA regulators took a different course. They issued a less-severe warning, noting that other safe and effective treatments are available for treatment of childhood depression.

Concerns Grow

Given the discrepancies in the data on paroxetine, the FDA proceeded in July 2003 to request new summary data from the makers of each of the eight other antidepressants it had already reviewed, breaking down adverse events like GSK had done into the categories of "possibly suicide related" and "suicide attempts." GSK had defined the two categories as "any events including thoughts or behaviors the sponsor considered to represent possible suicidality" and "a subset of possibly suicide-related events that included behaviors the sponsor considered to represent self-harm," respectively.

In summaries of the data from three clinical trials submitted on the use of fluoxetine (Prozac)—the only medication in the U.S. approved for pediatric depression—the suicide data are not only clear, they are consistent (see table below). In all three studies, there was no increased risk of suicide-related events or attempted suicide. Indeed, some statisticians would say that there is a "signal" that fluoxetine may be protective against these events, given that overall more suicide-related events and more attempts occurred on placebo than on fluoxetine. The difference between the two, however, was not statistically significant.

Data that the agency received on sertraline (Zoloft), citalopram (Celexa), nefazodone (Serzone), and mirtazapine (Remeron) were released at the February 2 advisory committee meeting. The data showed both more possibly suicide-related events and more suicide attempts in at least one trial for patients taking each of the active medications versus their respective placebo groups. Similar to the paroxetine data, the numbers differed between clinical trials of the same drug but were suggestive, FDA officials believed, of a "signal."

(Summary data of clinical trial adverse events for bupropion [Wellbutrin] and fluvoxamine [Luvox] were not released at the advisory committee meeting. *Psychiatric News* has filed a request with the agency for the data under the Freedom of Information Act.)

The FDA noted a more clear and disturbing trend in the data for venlafaxine (Effexor): one of the two studies showed patients taking venlafaxine were 5.3 times more likely to experience a suicide-related event compared with patients taking placebo. The second study showed patients taking venlafaxine to be about eight times more likely to experience a suicide-related event. As a result, Effexor's maker Wyeth voluntarily changed the drug's label to include a warning that the drug should not be prescribed to children under the age of 18 with major depression and issued a "Dear Doctor" letter explaining the data.

Patient-Level Data Need Scrutiny

The FDA had three concerns with the numbers submitted by each antidepressant manufacturer.

"In looking at the summary data that sponsors gave us," FDA's Laughren said at the advisory meeting, "it appeared that somewhat different approaches were used to capture and present these cases to us." Second, there was concern about how the adverse events being reported were classified into meaningful categories. Finally, he said, the FDA was concerned about the "inconsistency in the signal across individual studies within the programs."

The FDA had requested that each company not only provide the number of events and the terminology of how they were recorded, but also any narrative description of the adverse events, if available. The FDA received narratives for much of the data, but not all of them.

Analysis of the narratives revealed that a wide range of events was being listed under the broad category of "possibly suicide-related events" and even as suicide attempts. For example, according to Laughren, one event listed as a "possibly suicide-related event" described a child who became angry and banged his head into the wall two times. Without additional information, it wasn't clear whether the child actually intended that action to be life threatening.

Data Create Muddy Picture

Drug/Study	Possibly Suicide Related			Suicide Attempts		
	Drug	Placebo	***Risk Ratio***	Drug	Placebo	***Risk Ratio***
Paroxetine/329	6/93	1/88	***5.9***	5/93	0/88	–
Paroxetine/377	7/181	4/95	***0.9***	7/181	4/95	***0.9***
Paroxetine/701	1/104	1/102	***1.0***	1/104	1/102	***1.0***
Fluoxetine/HCCJ	0/21	1/19	–	0/21	1/19	–
Fluoxetine/HCJE	3/109	4/110	***.08***	0/109	2/110	–
Fluoxetine/X065	2/48	2/48	***1.0***	2/48	0/48	–

Source: Food and Drug Administration

The FDA asked drug makers to report "risk ratios" for each clinical trial, reporting any "possibly suicide-related event" or suicide attempt. A risk ratio compares the percentage of patients taking the medication who experience the event with the percentage of those on placebo who experience the same event. The paroxetine studies had widely variable risk ratios, whereas the fluoxetine studies were all consistently close to 1.0, indicating no difference between the two groups.

In contrast, Laughren said, an event that was classified in one study as an accidental injury involved a child who stabbed himself in the neck with a pencil at school after becoming frustrated with a test. Laughren noted that while that particular case may well have been an accident, it raised the issue that the agency might want to review all events of "accidental injury" to make sure no suicidal gestures were overlooked.

"One case classified as a suicide attempt," Laughren described, "was a girl who slapped herself in the face, and that was it." There were also six cases, he said, that were classified simply as "minor self-mutilation" with no identification of the self-harming behavior.

As the regulators reviewed the data, it became more and more clear that the data on hand were not sufficient to answer conclusively the question they were trying to answer. They not only needed *additional* data; they needed *better* data.

"The largest problem here is that the outcome of interest that we are tracking, which is suicidality, is also an outcome of the indication for which the drug is prescribed."

In the last three months of 2003, the FDA requested "patient-level data" for all 24 studies involving the nine medications under review. Essentially, the agency asked each pharmaceutical manufacturer to hand over individual patient records, collated into tables listing each patient in a given clinical trial, with numerous data points listed for each patient. This would give the agency a far more detailed look at what was happening than the summary tables normally supplied by drug manufacturers, in which only the number of events are listed and compared with the number of total patients exposed to the medication.

These data, the FDA believed, would allow the agency to reclassify all adverse events for risk of suicidal thoughts and behaviors using the same criteria and report the information in the same manner. With a clean, systematic approach, the agency would be able to answer the question at hand confidently. However, agency officials quickly realized that outside help would be needed for such an enormous undertaking, and so the agency turned to a group of suicidality experts at Columbia University and New York State Psychiatric Institute. The patient-level data will be given to the Columbia group for reclassification. The FDA plans to complete this analysis by mid to late summer.

In the meantime, the FDA has also analyzed the data it has received on each of the nine medications through its Adverse Event Reporting System.

Obviously, certain drugs have been on the market longer than others and thus are likely to have higher numbers of adverse-event reports associated with them compared with drugs on the market for only a brief time. To compare the nine medications in a systematic way, the FDA looked for any suicide-related adverse-event reports filed on each of the drugs during the first three years it was on the market (see table on page 1).

Interestingly, fluoxetine was associated with the most reports (34), nearly seven times the number filed for paroxetine (five). In contrast, escitalopram (Lexapro) and mirtazapine had only one report filed, and no reports were filed for nefazodone. Overall, most of the 78 reports involved females over the age of 12; the highest percentage of reports were classified as suicide attempts, which is consistent with epidemiological research on suicide, according to the FDA. There were seven completed suicides (four male, three female), of which six were by patients taking fluoxetine and one by a patient taking paroxetine.

"Interpreting these results, we would say that suicidality is reported with all drugs," said Andrew Mosholder, M.D., an FDA epidemiologist in the Office of Drug Safety, while testifying before the advisory committee. "The drugs with the largest numbers of reports coincided, roughly speaking, with the greatest amount of pediatric use."

Mosholder cautioned that the adverse-event reporting data are notoriously unreliable and represent underreporting of just about any event. While the data may be interesting, he said, they are of limited value in any quantitative comparison between drugs.

"The largest problem here," Mosholder noted, "is that the outcome of interest that we are tracking, which is suicidality, is also an outcome of the indication for which the drug is prescribed."

Data presented at the advisory committee meeting on SSRIs and suicidality, as well as a transcript of the meeting, are posted online at <www.fda.gov/ohrms/dockets/ac/cder04.html#PsychopharmacologicDrugs>. ■

from the president

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major advocacy efforts at the state and national levels.

Tom Hamilton, a member of APA's Corresponding Committee on Jails and Prisons and a past president of Texas NAMI, is an example of the fact that advocacy works. With strong lobbying, he convinced the Texas legislature to divert $35 million over a two-year period from the criminal justice system to provide mental health treatment at the back door of the prison system *(Psychiatric News*, October 3).

In the near term, the dual prejudices against criminals and mentally ill people conflate, making APA's undertaking these related projects a steep hill to climb. But the urgent needs of families, the community, and our society make these efforts critically necessary. ■

clinical & research news

Alzheimer's

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different treatment option for moderate-to-severe Alzheimer's now, and hopefully for patients with mild-to-moderate Alzheimer's in the future."

Based on Peskind's results and other data, Forest announced an intention to file a Supplemental New Drug Application with the FDA by this summer for approval of memantine in patients with mild-to-moderate Alzheimer's.

The most common treatment-emergent side effects noted in pooled analysis of all the clinical trials with memantine include confusion and headache. Interestingly, agitation, depression, accidental injury, and urinary and upper-respiratory-tract infections were all significantly lower in patients taking memantine compared with those taking placebo. ■

Managed Care

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physician participation in MediCal, the state's insurance plan for low-income Californians.

William Callahan, M.D., a California psychiatrist in independent practice, said it was while in his residency working in a university system with many managed care contracts that he saw the interference in patient care those plans entailed.

"I wanted to do both therapy and medical management, but frequently could not because the managed care plan split the treatment," said Callahan, who is a member of the *Psychiatric News* Editorial Advisory Board.

Lurie said the experience described by Callahan is typical of many psychiatry residents today, at least among those he has known in San Francisco. "A lot of the residents leaving training have felt so burnt," he said. "They ran the inpatient service and were the ones who made the calls and were told that they couldn't keep this patient for an extra day or that that patient had to be discharged because he or she wasn't suicidal on the day they called. It really turned them off."

Callahan likened the compromises and rationalizations a physician is forced to make to accommodate managed care to those that an abused party makes in acquiescence to an abusive relationship.

"I know countless physicians who are unhappy doing 10- and 15-minute med checks," he said. "But they don't see any other way to do it, because that's the way the reimbursement is."

But if opting out is not exactly an isolated phenomenon and is even in some areas of the country on the rise, it is nevertheless far from a trend. A November 2002 report by the Center for Health System Change found that more than nine of 10 physicians in 1997 and 2001 owned or were members of a medical practice that had at least one contract with a managed care plan (see chart on page 13).

Edward O'Neil, Ph.D., director of the Center for the Health Professions, which produced the report on California physicians, said that media attention to the increase in the number of physicians opting out of managed care obscured the more subtle and more important story from that report, which is the changing relationship between physicians and managed care organizations.

"While the number of physicians in California not taking payment from managed care increased, it wasn't a wholesale movement by any stretch," he told *Psychiatric News*. "These were single-digit adjustments."

The real news, he said, is that physicians are feeling somewhat more empowered to take back control of their practices in a variety of ways. In some cases, it is taking the form of independent practice.

It is just as likely, however, that physicians are moving in the opposite direction, joining large integrated systems of care, independent of the way they are financed, to take advantage of the benefits of financial stability, technology, and access to other physicians. And, in California, they are leaving behind the independent practice associations,

please see ***Managed Care*** *on facing page*

Making Independent Practice Work

By "opting out" of managed care, psychiatrist William Callahan, M.D., of Irvine, Calif., turned down the ready patient supply that contracting through managed care with large private and public employers provides.

So how does he make independent practice work?

"I have to know how to market myself through several channels," he told *Psychiatric News*. "I pursue a long-term strategy that involves working on multiple nonprofit boards, serving the community, and getting a lot of name recognition."

Callahan is active in the Orange County Medical Society, acquainting himself with more than a few primary care physicians. And he takes a keen interest in California's legislative affairs: he makes a point of knowing every legislator from Orange County who serves in the state Assembly in Sacramento. In these ways, he has made his name known to people who can refer patients to his practice.

Additionally, Callahan said he has been a frequent face on local cable television talk shows and speaks often to local print media reporters.

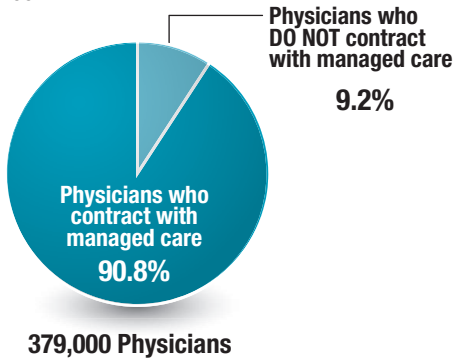
Finally, for several years Callahan has led a free group discussion for individuals who have a family member with a severe and persistent mental illness. "Often these individuals have trouble handling the emotions that come up with having to deal with a loved one who has a serious mental illness," he said. "They need to convince loved ones that they have to take their medication or they will never get well, so I need the families to act as an extension of me."

The work has the merit of providing a free and valuable service to individuals and families, while making his name known to hundreds throughout Orange County.

"I work with people who are short on money to spread out the sessions or shorten the sessions," Callahan said. "I have a lot of flexibility to match the treatment with the patient's finances and goals."

Nine Out of 10 Docs Still in MCO Plans

In 2001, 90.8% of a nationally representative sample of U.S. physicians responding to the Community Tracking Study Physician Survey signed contracts with managed care companies, nearly the same percentage that had done so in 1997.



Source: Center for Studying Health System Change

PTSD Program

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try to optimize whatever medications they are on at the time of admission."

Other kinds of treatments are offered as well, usually in a group format—for instance, cognitive-behavioral therapy, eye-movement desensitization and reprocessing (the goal of which is to access, neutralize, and resolve traumatic memories), art therapy for nightmares, and help for substance abuse (which affects some 40 percent of program participants).

"We used to think that if we treated patients' trauma, their addictions would go away," said Wright. "But that is unfortunately not the case."

Safety Emphasized

Probably the most striking aspect of the program is that it helps patients learn how to feel safe, since most have had violence perpetuated against them by another person. Its safety concept is based upon the Sanctuary Model developed by Philadelphia psychiatrist Sandra Bloom, M.D., in the 1980s and 1990s. In fact, in the early 1990s, Bloom told *Psychiatric News*, "I consulted with Homewood Hospital and Dr. Wright about the program that they were just starting, to help them set it up along the same line as ours. As far as their program is concerned, I think it is very good."

For instance, many patients in the program are afraid of going to sleep for fear that they will have nightmares about the traumas they have experienced. Yet their nighttime habits—say, smoking and drinking coffee in the middle of the night—may be making it all the harder for them to fall asleep. Wright and his coworkers try to alter such habits.

A number of patients do not allow themselves to feel emotions because they believe that emotions, especially anger, can endanger them. "We help them experience such emotions and acknowledge that they are acceptable," said Wright.

Some patients fail to recognize that their fears of being hurt once again are unrealistic in present circumstances. Wright and his colleagues help them come to this realization. For instance, as one patient said, "OK, Doc, you're right—my father is only 5 feet tall and weighs only 100 pounds at this point. So, yes, you're right—he can no longer assault me."

Patients who are sexual abuse survivors may dissociate as far as their bodies are concerned because it gives them a sense of protection. "So we have to work with them on the issue of physical safety," Wright said.

Wright and his team have also been conducting research to assess the value of their program to various types of patients. For example, they are doing an outcomes study on a cohort of Canadian soldiers and Canadian veterans of peacekeeping missions who participated in the program.

"Some of our hoped-for areas of growth," Wright concluded, "are developing more integrated treatments for PTSD and addiction and looking at ways to partner with First Nations [Canadian Indians, Eskimos, and other native Canadians] to deal with trauma in their communities." ■

Managed Care

continued from facing page

the loose network of office-based physicians that had been the primary mechanism by which doctors contracted with managed care.

At the same time, the Center for Health Professions report on California physicians found that health plans are moving away from strict capitation toward preferred provider organizations (PPOs) that allow for reimbursement of out-of-network physicians. Data from the CSHSC confirm the same trend nationally.

For this reason, O'Neil said the degree of a physician's involvement with managed care becomes a matter of semantics: what many doctors think of as "managed care"—the strictly capitated HMO—is no longer the predominant model.

In contrast, PPOs can involve many features of managed care, including some that have been found objectionable by physicians. O'Neil said that 90 percent of Californians are covered by some kind of managed care.

For just that reason, opting out is not liable to become widespread any time soon. "I don't see it as a trend," said Callahan. "For one thing, it's risky. When you sign a contract, you have a big business funneling you all kinds of patients. The physician doesn't have to market himself, and there is a guaranteed patient flow. There's a security to that."

Emmons agreed that to "go it alone" can be anxiety producing, but he believes it can be done. He said he works 20 clinical hours and earns $75,000 a year. "That's lower than many, but I'm working 20 hours with only five hours of administrative time," he said.

He added, "I've never known a colleague who opted out who failed. But I have known some who practiced in managed care and left medicine altogether because they were demoralized." ■

Professional News

Nominations Invited

Nominations are now being sought for the Moffic Award for Ethical Practice in Community Psychiatry, sponsored by the American Association of Community Psychiatry, the Moffic family, and an anonymous donor.

The award is an expanded version of a prior award that focused solely on managed care in the public sector and now covers any ethical challenge in community psychiatry.

Nominations are invited of any clinician, administrator, organization, or consumer who has met ethical challenges in the public sector, such as those related to managed care, relationships with pharmaceutical companies, political activism, stigma reduction, education, consumer advocacy, and treatment and service delivery.

The award includes presentation at a national meeting and at least $2,000.

Nominations should be sent by January 1, 2005, to Steve Moffic, M.D., by e-mail at bpernitz@mail.mcw.edu or fax at (414) 456-6295. ■

Election Results

continued from page 1

Steven S. Sharfstein, M.D.: "APA is. . .the most important voice to advocate for our patients and our professional values."

treasurer. Robinowitz, who won with 58.9 percent of the vote, is a private practitioner, a member of the Board of Directors of American Psychiatric Publishing Inc., and an APA delegate to the AMA House of Delegates.

In races in which there are more than two candidates, APA uses a "preferential voting system" in which voters are asked to rank the candidates in the order in which they would like to see them win. If no candidate garners a majority on the first round of counting, the candidate with the lowest number of votes is eliminated, and the second-choice votes on the ballots cast for him or her are distributed to the remaining candidates. In the race for treasurer, Robinowitz won on the first round of counting.

In the election's other three-way race, Renée Binder, M.D., of San Francisco emerged as the winner of the trustee-at-large contest in the second round of counting with 58 percent of the vote. Her opponents were Jeffrey L. Geller, M.D., M.P.H., of Worcester, Mass., and Michael Vergare, M.D., of Philadelphia.

APA members-in-training chose Daniel T. Mamah, M.D., of Washington University in St. Louis to be their next member-in-training trustee-elect. Mamah defeated John Kuzma, M.D., of the University of Iowa in Iowa City with 65.7% of the vote.

Two of APA's seven Areas elected a trustee this year. Roger Peele, M.D., was re-elected as the Area 3 trustee in an uncontested race. In Area 6 Thomas Ciesla, M.D., defeated Barry Chaitin, M.D., with 56.5 percent of the vote.

The tenure of the newly elected Board members begins at the close of APA's 2004 annual meeting in May. At that time the current president-elect, Michelle Riba, M.D., will become APA president.

The 2004 election reflects for the first time changes made to the composition of the Board of Trustees since the Board voted to downsize itself in late 2002. The plan called for eliminating one of the two vice-president positions and combining the secretary and treasurer positions. APA voting members approved these changes in the 2003 election.

Pedro Ruiz, M.D., who was elected for a two-year term in the 2003 election, is now APA's sole vice president. Robinowitz, who was elected treasurer in the 2004 election, will become secretary-treasurer in 2005, at the end of the term of the current secretary, Nada Stotland, M.D.

This year, there were 30,261 eligible voting members. Of that number, 31.1 percent, or 9,408, voted. Approximately 8 percent of those voting did so online.

Detailed election results appear in the chart below. ■

APA Election 2004 RESULTS:

President-Elect

Steven S. Sharfstein, M.D.
6,170
66.5%

Jagannathan Srinivasaraghavan, M.D.
3,105
33.5%

Total votes cast: 9,275

Treasurer

First choice votes:

Carolyn B. Robinowitz, M.D.
5,413
58.9%

Albert C. Gaw, M.D.
2,204
24.0%

Patrice A. Harris, M.D.
1,572
17.1%

Total votes cast: 9,189

Trustee-at-Large

First choice votes:

Renee L. Binder, M.D.
3,790
42.2%

Jeffrey L. Geller, M.D, M.P.H.
2,652
29.5%

Michael J. Vergare, M.D.
2,549
28.4%

First + Second choice votes:

Renee L. Binder, M.D.
3,790 + 899 = 4,689
58.0%

Jeffrey L. Geller, M.D, M.P.H.
2,652 + 745 = 3,397
42.0%

Total votes cast: 8,086

Member-in-Training Trustee-Elect

Daniel T. Mamah, M.D.
459
65.7%

John M. Kuzma, M.D.
240
34.3%

Total votes cast: 699

Area 3 Trustee

Roger Peele, M.D. (unopposed)

Yes
1,268
95.3%

No
63
4.7%

Total votes cast: 1,331

Area 6 Trustee

Thomas K. Ciesla, M.D.
582
56.5%

Barry F. Chaitin, M.D.
449
43.5%

Total votes cast: 1,031

HOUSE AD

Budget

continued from page 6

crease over Fiscal 2004 for the National Institute of Mental Health and the National Institute on Drug Abuse. The president's proposed increase for the National Institute on Alcohol Abuse and Alcoholism is 2.9 percent.

The corresponding dollar increases over the current year are $39 million, $28 million, and $13 million, respectively, according to the budget review.

"Because these rates will neither keep pace with medical inflation nor the pace of research opportunities, APA, in concert with the Ad Hoc Group for Medical Research Funding, the Coalition for Health Funding, and the Mental Health Liaison Group, will call on Congress to provide additional funds," states the coalition's budget review.

Bush has proposed a 6 percent increase of $199 million for SAMHSA in Fiscal 2005. This would give the mental health agency a budget of $3.6 billion.

"Overall, the SAMHSA budget includes $2.5 billion (a net increase of $148 million or 6 percent) for substance abuse treatment and prevention activities," the budget review states.

The Center for Mental Health Services (CMHS) would receive a $50.6 million increase over Fiscal 2004 in the president's budget request. The bulk of those funds ($44 million) are designated for new State Incentive Grants for Transformation, which are designed to help states develop comprehensive mental health plans.

The president also proposed an increase of $3.6 million for the Comprehensive Community Mental Health Services for Children and Their Families Program and a $5.2 million increase in funding over last fiscal year for the Projects for Assistance in Transition from Homelessness (PATH) program. The president's budget for the current fiscal year also included large increases for these two programs *(Psychiatric News*, March 6).

Boroughs praised the president for funding the new state incentive grants but said it should not come at the expense of community grant programs for jail diversion and improving mental health services to the elderly. The president's Fiscal 2005 budget would cut $8 million in funding for these program categories. This would leave $4 million in funding for the jail-diversion program and erase all funding for mental health outreach to seniors, according to Boroughs.

"APA is aggressively lobbying members of the House Appropriations Committee to restore the funding for those two programs," said Boroughs.

The president's Fiscal 2005 budget request for HHS is posted online at <www.hhs.gov/budget/docbudget.htm>. ■

Dining

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Water's Edge. There's free ferry service from the East Side of Manhattan over to Long Island City, Queens, and it's direct to this wonderful seafood establishment with a view to match. Sit back and relax.

Another ferry you shouldn't pass up is the world-famous Staten Island Ferry, which is, incidentally, the least expensive (it's free) and thoroughly New York experience to partake of. You'll enjoy some of the most stunning views of Manhattan, Brooklyn, Governor's Island, Staten Island, New Jersey, and the Verrazano Bridge while on your way to **Carol's Café.** It's a little bit of a trek but worth it. And hey: you're adventurous, right? You're a chowhound and willing to go anywhere for good food, right? Then Carol's should be on your list. The chef, Carol Frazzetta, is obsessed with providing you with a fresh and international take on her superb cooking. She's prepared one of the most eclectic menus, full of surprises for the intrepid diner. Who knew? One of New York City's undiscovered gems.

And speaking of gems: ever been to the Bronx? Yeah. Da Bronx. It ain't whattcha-think anymore, especially at **Le Refuge Inn** on City Island. The Gallic cuisine in the mansion on the island is outstanding. And if you're too tired to come into Manhattan after filling up here, you can spend the night in one of the inn's rooms! And if you do, you'll have time to enjoy another meal at **Roberto's.** Get there early, though. There's always a wait, and the restaurant doesn't take reservations. Once you're in, just say, "Bring me a taste of everything" because everything on the menu is worth eating. Seriously. And hey, if you have to wait for a table, just strike up a conversation with one of the regulars who didn't make it earlier enough either. Guaranteed, you'll be glad you did. A great neighborhood and a great experience.

Are you as stuffed as I am? I know, I know. But there's so much more! I've just started to introduce you to all that New York City has to offer. In this article, I wanted to get you out of Manhattan for a bit. Next up: Really-out-there cuisine you can't find anywhere else. That's it for now. I'll be baaaack. . . . ■

Beyond Manhattan

- **Alama**: 187 Columbia Street, Brooklyn, (718) 643-5400
- **Al Di La:** 48 Fifth Avenue, Brooklyn, (718) 783-4565
- **Carol's Café:** 1571 Richmond Road, Staten Island, (718) 979-5600
- **Grimaldi's:** 19 Old Fulton Street, Brooklyn, (718) 858-4300, www.grimaldis.com/brooklyn.htm
- **The Grocery:** 288 Smith Street, Brooklyn, (718) 596-3335
- **Le Refuge:** 620 City Island Avenue, Bronx, (718) 885-2478, http://lerefugeinn.com/index.php?menu=1
- **Patois:** 255 Smith Street, Brooklyn, (718) 855-1535, www.patoisrestaurant.com
- **Roberto's:** 632 East 186th Street, Bronx, (718) 733-9503
- **Water's Edge:** 44th Drive and East River, Queens, (718) 482-0033, www.watersedgenyc.com

Jail Diversion

continued from page 1

cording to a 1999 Department of Justice report, "Mental Health Treatment of Inmates and Prisoners."

Inmates with mental illness are more expensive to treat than other inmates due to overtime payments to corrections staff for suicide watches, higher medication costs, and longer stays, said Daniel Souweine, policy analyst at the Council of State Governments.

Diversion Programs Promising

Henry Steadman, Ph.D., president of Policy Research Associates, deplored the lack of empirical studies on jail-diversion programs, saying that only a handful of published studies exist, which he reviewed at the conference.

Henry Steadman, Ph.D., reports that mentally ill people in jail-diversion programs had fewer jail and hospitalization days than mentally ill people who were not diverted.

PRA operates the National GAINS Center for People With Co-Occurring Disorders in the Justice System, an initiative funded by the Substance Abuse and Mental Health Services Administration.

Steadman cited seven published studies of diversion programs conducted between 1995 and 2002. The combined results showed that diverted individuals had fewer jail days and psychiatric hospital days than mentally ill individuals who were not diverted, according to Steadman.

Diverted individuals were typically women with a primary diagnosis of schizophrenia or mood disorder with psychotic features, on federal Supplemental Security or disability income, and with higher scores on the Colorado Symptom Inventory than the nondiverted group, indicating that the diverted individuals had better mental health and quality of life, according to Steadman.

The SAMHSA Jail Diversion Initiative, a nine-site unpublished study of people with co-occurring disorders between 1998 and 2000, produced similar results, according to Steadman. PRA provided technical assistance and some data analysis for the SAMHSA initiative.

"Despite more days in the community, diverted participants had comparable rearrest rates in the 12-month follow-up period, which shows the risk to public safety isn't greater, which is often raised in arguments against jail-diversion programs," Steadman said.

Bottom Line: More Data Needed

Alexander Cowell, Ph.D., an economist for the Research Triangle Institute International, analyzed the cost-effectiveness of jail diversion compared with standard jail treatment at four of the nine study sites. Cowell said at the conference that cost-effectiveness was defined as "the costs of resources associated with the intervention and the effectiveness of the intervention."

One year later, jail costs decreased in jail-diversion programs while treatment costs increased due to more intensive services. As a result, there was no cost savings in jail-diversion programs compared with standard jail practices.

Treatment in diversion programs produced only one significant clinical outcome at each of the four sites. For example, diversion was associated with a reduced risk of drug use by 80 percent at no extra cost at one site and improved scores on the Colorado Symptom Inventory at two other sites, according to Steadman.

He pointed out, however, "A limitation of these studies is that the data were collected for only one year after diversion to treatment. What we really need is a well-designed prospective, longitudinal study, but no one has taken that on yet."

To that end, David Hughes of the Human Services Research Institute has developed a computerized-simulation model that can be used to project treatment outcomes and cost estimates for mental health treatment in jail-diversion programs and the criminal justice system. The simulation model is being pilot-tested in at least one jail-diversion site.

"The model strongly suggests that there may be a cost savings two to three years after diversion," Steadman said.

The participants agreed that it would be worthwhile to produce a resource document on the fiscal implications of jail diversion and criminalization that could be used by different audiences and updated as the need arose.

The GAINS Center has published several resources on jail diversion, including some focused specifically on women and juveniles. The publications are posted online at <www.gainsctr.com/b/publications/default.asp#6>. ■

government news

Execution

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by Deborah Robinett, D.O., treasurer and legislative representative of the Wyoming Psychiatric Association. Following their presentation, the House Judiciary Committee voted unanimously to support the proposed legislation, paving the way for eventual passage.

Later this year, the U.S. Supreme Court will hear arguments in a case challenging the constitutionality of executing those who were younger than age 18 when they committed their crimes. That case, *Donald P. Roper v. Christopher Simmons*, is an appeal on a case in which the Missouri Supreme Court overturned Simmons' death sentence, finding that executing a 17-year-old violated the Eighth Amendment's prohibition against cruel and unusual punishment.

In the 2002 *Atkins v. Virginia* case, the Court ruled that executing mentally retarded individuals was a violation of the Constitution's ban against "cruel and unusual punishment."

More information on these bills and juveniles and the death penalty is posted at the Web site of the Death Penalty Information Center at <www.deathpenaltyinfo.org/article.php?did=205&scid=27>. ■