Volume 39
Number 8
April 16, 2004

Newspaper of the
American
Psychiatric
Association

PSYCHIATRIC NEWS

"See" references appear on pages 8, 18, 48

Bruce Hinrichs, M.D. (left), president of the New Mexico district branch, and Mark Munetz, M.D., president of the Ohio Psychiatric Association (OPA), addressed APA's Board of Trustees last month. Hinrichs talked about the status of his state's psychologist-prescribing law, while Munetz reported that OPA's membership was increasing. See story on page 7.

Clinical & Research News

FDA Orders Stricter Suicide Warnings for Antidepressants

Amid allegations of a cover-up, the FDA has urged physicians to monitor closely all patients during the first weeks of antidepressant therapy and during any dose titrations of their medication.

BY JIM ROSACK

Following the advice of its Psychopharmacologic Drugs Advisory Committee, the U.S. Food and Drug Administration (FDA) has told the manufacturers of 10 antidepressant medications to change their labels to include stronger, more-specific warnings regarding the possibility of worsening depression or suicidality emerging during therapy with the drugs. The agency called the new warnings prudent, even though it cautioned that no solid evidence exists to link the medications to increases in self-harming and suicidal behaviors.

Two weeks after the new warnings were issued, the agency found itself on the defensive, as two congressional inquiries were initiated into what evidence actually exists and how forthcoming the agency has been on the issue. Specifically, members of Congress want to know whether the FDA may have prevented an agency medical officer, Andrew Mosholder, M.D., from presenting all the details of his analysis of the original clinical trial data on SSRIs and suicide risk.

Mosholder's report to the advisory committee meeting on the issue (*Psychiatric News*, March 5; March 19) was pulled from the meeting agenda at the last minute, according to a March 31 article in the *San Francisco Chronicle*, which first broke the story. Mosholder's report allegedly indicated that the evidence linking SSRIs and suicide is much stronger than the agency has publicly acknowledged.

Rep. James Greenwood (R–Pa.), chair of the investigations subcommittee of the House Energy and Commerce Committee, along with Sen. Charles Grassley (R–Iowa), chair of the Senate Finance Committee, initiated investigations to determine what Mosholder's original report said and whether the FDA suppressed its release, allegedly out of fear that it would put the agency at odds with the pharmaceutical industry.

An FDA spokesperson said that the agency "would review the [Congressional] requests and respond to them as quickly and completely as possible."

Nonetheless, seven weeks after a contentious and emotional public advisory committee meeting on the risk of treatment-emergent, self-harming behaviors associated with SSRI use in children and adolescents, the FDA told physicians prescribing antidepressants to monitor carefully any patient—regardless of age—receiving one of the 10 medications for "possible worsening of

please see ***FDA*** *on page 90*

Primm Will Spearhead APA's Minority Affairs Initiatives

Association N

Mental health issues affecting minority populations will receive additional attention at APA now that a new director is about to take the helm of the Department of Minority and National Affairs.

BY KEN HAUSMAN

APA Medical Director James H. Scully Jr., M.D., announced at last month's Board of Trustees meeting that he has chosen Baltimore psychiatrist Annelle Primm, M.D., M.P.H., to be the new director of the Department of Minority and National Affairs. Primm will begin her new duties on April 26.

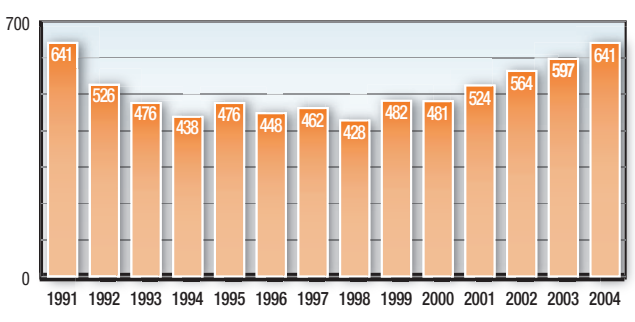
Annelle Primm, M.D., will head the APA Department of Minority and National Affairs.

Primm is director of community psychiatry at Johns Hopkins Hospital and is an associate professor of psychiatry at Johns Hopkins School of Medicine. She also holds an appointment in health policy and management in the university's School of Public Health.

She has served as vice president of the American Association of Community Psychiatrists. She told *Psychiatric News* that she is especially interested in community psychiatry because of "its focus on populations and on the social, economic, and political context of mental health."

please see ***Primm*** *on page 95*

Match Growth Continues



Source: National Resident Matching Program 2004

The number of U.S. medical graduates matching into general psychiatry residencies continues an upward trend. See page 34.

Magellan's New Medical Director Responds to Challenges, Criticism

The new director of the nation's largest mental health care carveout explains why he believes better use of data and integrating mental health and primary care will improve his company's relationship with psychiatrists, patients, and employers.

Professional News

BY KATE MULLIGAN

A top priority for Alex Rodriguez, M.D., the new medical director of Magellan Health Services Inc., is to integrate behavioral and primary care services.

In a recent interview, he told *Psychiatric News*, "Integrated disease management is our future. There's big momentum [in support of the concept]."

He said that this support comes from employers and employee benefits managers, who pushed the establishment of "carveouts" to provide and manage mental health services and now are realizing the limitations of that model.

Rodriguez pointed out that the National Committee for Quality Assurance (NCQA), a private, nonprofit organization that issues an annual report evaluating health care organizations on various measures, has added standards concerning integration of care to its evaluations of managed health care companies.

He was chair of the NCQA's Behavioral Standards Subcommittee from its inception in 1996 until 2001.

In its September 2003 report, the NCQA flagged mental illness as an area in which the health care system "continues to struggle."

Magellan to Integrate Care

How can Magellan, which is itself a carveout company, promote integration of care?

Rodriguez believes that "more sophisticated data systems," such as that used by Magellan, will enable psychiatrists and health care professionals to better identify patients at risk for diseases that might not be readily apparent.

He said, "As Magellan clearly is the biggest company in the behavioral health care industry, our database is the most capable of supporting this effort."

Rodriguez also described a model in which primary care doctors receive training to enable them to identify patients who need referrals for mental health services. The program recently was rolled out in Georgia by Blue Cross/Blue Shield of Georgia and Magellan, with support from researchers at Duke University School of Medicine and the MacArthur Foundation.

"It's a prototype that's being evaluated," Rodriguez said. "If successful, we would expect to try to implement it in every state in which we do business."

He added, "If Darrel Regier [director of APA's Office of Research] and others are right, costs for mental health services will go up, but they will be more than offset by a decrease in other medical costs."

Alex Rodriguez, M.D: "I would have no hesitation in going to any group of payers and saying that the mental health benefit is more accountable than the general medicine benefit."

Employer Education Planned

Rodriguez plans to point out to employers who are reluctant to offer mental health benefits the costs associated with employee absenteeism or presenteeism that come from untreated mental illnesss.

He said he also will make a case to employers that there is greater accountability to employers for the quality and costs of mental health benefits than for most medical services.

"I would have no hesitation in going to any group of payers and saying that the mental health benefit is more accountable than the general medicine benefit."

Rodriguez plans to expand Magellan's research efforts and hopes to establish a mental health research alliance with other organizations, such as APA.

According to the 2002 National Survey of Psychiatric Patients conducted by the American Psychiatric Institute for Research and Education's Practice Research Network, 52 percent of responding psychiatrists are not on any managed care panels (*Psychiatric News*, March 19, 2003).

In the same article, Lawrence Lurie, M.D., chair of APA's Committee on Managed Care, said, "Psychiatrists in managed care work with low fees, administrative hassles, and late claim payments."

Rodriguez responded to those data and concerns in a number of ways.

He submitted trend data, for example, that show an increasing number of psy-

please see ***Magellan*** *on page 4*

From Vision to Action

BY MARCIA GOIN, M.D.

In 2002 then APA president Paul Appelbaum, M.D., appointed a task force chaired by Steve Sharfstein, M.D., to develop a statement defining the form for a genuine system of mental health care. The task force produced a splendid document, "A Vision for the Mental Health System." It told Americans how an effective mental health system should be shaped.

The timing coincided with the work of the President's New Freedom Commission on Mental Health, a copy of which was provided to the commission to use in its deliberations. Would the president's commission truly describe the deplorable state of today's mental health system? We had our answer in the letter of transmission from the commission to President Bush in which the commission declared that the mental health care system was in a "shambles" and that a "fundamental transformation" of the mental health care system was needed to restore its capacity to provide for the mental health needs of the American people.

APA's vision statement described where we needed to go *(Psychiatric News*, May 16, 2003). As a follow-up to the vision report, I asked a group to work with Dr. Appelbaum and develop a roadmap to guide decision makers in transforming the vision into a reality. The Ad Hoc Work Group to Actuate the Vision presented its work to the acclaim of the Board of Trustees in March *(Psychiatric News*, April 2).

The work group report identifies seven themes derived from the vision statement's principles as a guide for the implementation:

- **Creation of an effective system for delivering mental health care**
  - A. Integrating general health and mental health care
  - B. Providing for the special needs of persons with more severe mental disorders
  - C. Reaching out to underserved areas and groups
- **Provision of appropriate coverage**
  - A. Creating universal and nondiscriminatory coverage for mental health treatment
  - B. Offering adequate reimbursement for mental health treatment
- **Development of an adequate workforce to meet the country's mental health services needs**
- **Moving toward a patient-centered, culturally competent mental health care system**
- **Reducing the stigma of mental disorders**
- **Improving the quality of mental health care**
- **Promoting research on mental disorders**

For each theme, the report provides objectives to accomplish the goal and strategies to bring each objective to fruition.

For example, take the first theme:

1.1 Creation of an effective system for delivering mental health care

1.1.1 Develop a model of care and guidelines for funding based on the core principles of the Community Mental Health Act of 1963, including a nationwide system of catchment areas, each of which contains an entity with responsibility for all persons with serious and persistent mental disorder. Finance this system by means of an integrated stream of federal, state, county, and insurance funding. Promote this model as the best long-term solution to the needs of the population with serious and persistent mental disorders throughout the country.

1.1.1.1 Identify and promote appropriate roles for psychiatrists in community-based systems, highlighting their value as team leaders and emphasizing the counterproductive effects of limiting their involvement to medication evaluation and prescription. Full integration of treatment for substance use disorders and other psychiatric services, regardless of venue, for all programs, including primary care settings as appropriate.

1.1.2 Expand this model to address treatment occurring in the private sector and encourage flexible financing for the full range of services available to meet the needs of patients.

1.1.3 Develop a complementary model for the integration of psychiatric and other medical services in organized settings of care, based on the principle that many psychiatric disorders can be treated by primary care physicians who have adequate training and ready availability of psychiatric consultation—and that a sufficient number of psychiatrists is not likely to be available in the foreseeable future to care for all persons with psychiatric disorders.

I've quoted only a few of the recommendations laid out by the work group to give you a sense of the direction and quality of the work product. Dr. Appelbaum and his dedicated work group have given us a compass and the motive power to implement our vision for a regenerated mental health system that will be responsive to our national needs. The work group's product is also a work in progress, as are all of our advocacy agendas, to be reshaped according to the exigencies of our time. The statement has been sent to all of APA's councils, committees, and other components; the Assembly; and other colleagues who have made contributions. If you are interested in joining in on a review of this process, let me know at mgoin@usc.edu. ■

Advertising Revenue Helps APA Meet Its Objectives

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

APA requires that all advertising in its publications be factually accurate, appropriate, and in good taste and aimed at contributing to the advancement of the profession of psychiatry. To that end, the editors of APA's three periodicals *(American Journal of Psychiatry*, *Psychiatric News*, and *Psychiatric Services)* are guided by the "Principles and Guidelines of Advertising Acceptance," developed in 1972 and revised as the need arises.

Proposed advertisements are normally reviewed for acceptability by the managing editors of each periodical. The managing editors (in consultation with their respective editors in chief as necessary) collaborate in those reviews and ordinarily speak as a group to accept, reject, or seek modification of an advertisement. However, final authority for acceptance or rejection of an advertisement rests with the editor in chief of the periodical to which the advertisement was submitted.

Also, the editors may refer an advertisement to the APPI Committee on Advertising for its opinion. The committee's recommendations are advisory, and no advertiser enjoys any right to such a referral.

In 1982 APA moved its advertising sales function in-house for better organizational and fiscal control and hired a director of advertising sales. The Advertising Sales Office was established in Northern New Jersey, where many of the pharmaceutical companies and their advertising agencies are located.

At that time, advertising revenue for the *American Journal of Psychiatry*, *Psychiatric News*, and *Psychiatric Services* was approximately $1.5 million. There were about 26 branded pharmaceutical products being promoted. Most of them were antipsychotics, anxiolytics, and TCAs. Also, there were five industry-supported symposia (ISS) at the annual meeting, accounting for eight pages of advertising in *Psychiatric News.* For this year's annual meeting, there are 54 ISS being promoted through 261 pages of advertising.

Advertising sales in the APA's three periodicals have been rising rapidly since 2001 because of the release of new pharmaceutical products. Pharmaceutical advertising revenue for 2003 climbed to $7.5 million, up nearly $1.4 million, or 22 percent, over 2002, and was spread across 30 branded and generic products. In addition, classified and nonpharmaceutical display advertising revenue accounted for $2.7 million. The total 2003 advertising revenue of $10.2 million represented 17 percent of APA's revenue for that year.

Other medical specialty publications have experienced a reduction of advertising revenue mainly because of a shift to direct-to-consumer advertising. This has not occurred in psychiatry, primarily due to FDA approval of new central nervous system products.

In 2003 many new products contributed to the additional revenue—Forest's Lexapro, Bristol-Myers Squibb's Abilify, GlaxoSmithKline's Lamactil, and Eli Lilly's Strattera, Cymbalta, and Symbyax. Additional revenue stemmed from new indications for Pfizer's Xanax XR and Solvay's Klonapin. These products have enabled our profession to provide improved treatment for our patients with ADHD, schizophrenia, bipolar disorder, Alzheimer's disease, depression, anxiety, and sleep disorders.

Advertising revenue can be volatile. In times of economic downturn, advertising is among the first expenses cut. And there is a risk of losing revenue if a drug is pulled off the market. There is also no way to predict how long an introductory advertising campaign will last.

It is important that we be open with our members regarding our relationship with the pharmaceutical industry. ■

Magellan

continued from page 2

chiatrists on Magellan's provider panels. In January 2002, Magellan contracted with approximately 42,000 providers of mental health services, of whom 6,881 were psychiatrists. In January 2004, the figures were 57,000 and 7,817, respectively, he said.

Rodriguez also offered trend data from Magellan's annual provider-satisfaction survey. "Overall satisfaction" with Magellan increased from 81.6 percent in 2002 to 84.3 percent in 2003.

Satisfaction with accuracy of claims payments increased from 79.2 percent to 83.2 percent and with timeliness of claims payments from 73.9 percent to 78.6 percent.

The percentage of those who would accept a referral from Magellan (94.4) did not change between the two years.

Rodriguez mentioned changes on Magellan's Web site that enable psychiatrists to request authorization for continued sessions for outpatient mental health or substance abuse treatment.

The redesigned site offers new features that allow practitioners to check member eligibility, the status of authorization requests and submitted claims, and credentialing or contracting status.

Rodriguez will meet with APA's Managed Care Committee at the APA annual meeting in May.

Lurie said, "Some of the data were surprising. We will be interested in discussing various issues related to their collection and analysis with Dr. Rodriguez at that meeting." ■

Contest Urges Teens to Weigh Consequences of Keeping Secrets

The sixth "When Not to Keep a Secret" national essay contest is reaching an end. Once again, APA district branches help make the contest a big success

BY JOAN AREHART-TREICHEL

The "When Not to Keep a Secret" national essay competition was launched in 1998 by the APA Alliance to encourage teens to ponder the importance of divulging a friend's confidence when the friend indicates plans to commit suicide.

Every year since then, the competition has grown bigger and better, and this year's—the sixth—is in its final lap, as the top three winners will be announced at the forthcoming APA annual meeting in New York City.

How the competition has gotten this far, however, is due not only to the APA Alliance, but also various organizations, notably APA district branches, and the American Psychiatric Foundation, which has provided financial support.

Here is an overview of the timeline that the 2003-04 national competition has followed and some of the groups that have contributed to the competition in this period:

• The competition started in September 2003 at the county level. The APA Alliance members in participating counties, along with the local APA district branch or other like-minded organizations, launched the project.

For example, the San Diego Psychiatric Society and the Yellow Ribbon Suicide Prevention Program helped Friends of the San Diego Psychiatric Society with the project in San Diego County, Calif. The California Medical Association Alliance, the Atwater Silverlake Rotary, and the Yellow Ribbon Suicide Prevention Program helped APA Alliance members with the project in Los Angeles County, Calif.

The California Medical Association Alliance, in collaboration with the California Psychiatric Association and the California Medical Association, agreed to sponsor the project at the state level.

• In December 2003, entries from students in school districts in each participating county were judged.

• On January 9, each participating county turned its top three essays over to the APA Alliance for state-level judging.

• On February 28 each participating state sent its three highest-ranked essays to the APA Alliance for the national competition. The essays will be judged by nationally recognized leaders in psychiatry, media, literature, and civic affairs, Alicia Muñoz, chair for the annual contest, told *Psychiatric News*.

The first prize will be a state-of-the-art computer system and printer. The winner will be honored at the joint luncheon of the APA Assembly and Board of Trustees on Sunday, May 2, during APA's annual meeting in New York City.

The states participating in this year's competition included Alabama, Arizona, California, Kentucky, Nevada, New York, Pennsylvania, South Carolina, and Utah.

More information about the essay project is posted online at <www.apaAlliance>. ■

Alicia Muñoz, chair of the "When Not to Keep a Secret" essay contest (second from left), and APA member Jorge Zapatel, M.D. (right), who helped promote the contest, pose with four San Diego teachers who participated in the contest. The APA Alliance launched the contest in 1998.

Volunteers Needed

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

Board Backs Pilot Test Of DB Recruitment Plan

APA's Board of Trustees confronts controversial membership plans from two district branches and debates a plan to permit uncontested races for president-elect.

BY KEN HAUSMAN

APA's Board of Trustees has found a solution, at least in the short term, for one of the more troubling issues it has confronted in the last few years—threats by two district branches (DBs) to establish an "affiliate" category that would circumvent APA's requirement that members belong both to the national organization and a DB.

In a memorandum to the Board, APA counsel JoAnn Macbeth pointed out that "the dual-membership requirement is long-standing APA and DB policy and is reflected in numerous APA programs, procedures, and corporate documents, including the APA Bylaws, which require APA members to be DB members" unless the Board grants an exemption.

"It is incumbent on the Board of Trustees," she added, "to review DB actions that are inconsistent with the dual-membership policy to consider implications for APA and to determine what steps are appropriate as a corporate matter."

Assembly Speaker Prakash Desai, M.D. (left), updates the Board of Trustees on the progress of his work group to develop criteria for sharing APA's nondues revenue with district branches. Area 6 Trustee Maurice Rappaport, M.D., looks on.

At their March 12-14 meeting at APA headquarters in Arlington, Va., Board members voted to accept a plan by one of those DBs—the Washington State Psychiatric Association (WSPA)—in which the DB shelved its affiliate-category proposal in exchange for APA's financial support of a new-member recruitment effort.

The other DB planning to implement a new member category—the Texas Society of Psychiatric Physicians—did not offer an alternative plan by the time of the March meeting. At a January roundtable meeting in Tucson, Ariz., APA President Marcia Goin, M.D., Medical Director James H. Scully Jr., M.D., and Assembly Speaker Prakash Desai, M.D., had asked leaders of the two district branches to work with them to develop a member recruitment and retention plan that would not rely on introducing a new membership category that violates the dual-membership requirement.

The centerpiece of the recruitment plan the WSPA proposed in lieu of a new affiliate category, and which the Trustees accepted, sets national dues for new members at the reduced rate of $90 for the first two years instead of $180. After that, dues would be the same as the regular national dues—$180 in the third year of membership, $360 in years four to six, and $540 thereafter. Lapsed members who want to rejoin during this two-year pilot project would pay the regular national dues, but would be given amnesty for unpaid dues from prior years.

In addition, new WSPA members would receive incentives such as free registration at an annual meeting, a discount coupon for American Psychiatric Publishing Inc. books, and a free subscription to *Focus*, APA's "journal of lifelong learning."

APA will also fund a WSPA recruitment drive that describes the benefits of APA and DB membership and regional meetings in eight areas of Washington state. In addition, APA will provide financial assistance to form a mentoring program directed at residents and early career psychiatrists.

The results of the two-year pilot project will be assessed each year, and at its conclusion APA will decide whether to continue it or expand it to other DBs.

Trustees expressed their disappointment that the Texas DB had not developed an alternative plan to creating a new member category. The Board went on to discuss a statement saying that "if the [Texas DB's

affiliate membership plan] was implemented, the program would constitute the establishment of a new membership category. In addition, the Board unanimously concurred with the Assembly Executive Committee's recommendation that APA not approve such an affiliate program and affirmed [APA's] long-standing dual-membership policy."

The Board then voted to inform Texas DB leaders that it would make the same recruitment program available to them that was earlier approved Washington state.

Uncontested Elections Defeated

The Trustees extensively debated a proposal from the APA Nominating Committee to allow future nominating committees the option of selecting only one candidate to run for president-elect. Nominating Committee Chair Paul Appelbaum, M.D., explained that the option for running an unopposed candidate would be used only in "exceptional circumstances," when committee members could not identify more than one competitive, well-prepared candidate for president-elect. That candidate is usually the APA senior vice president, who almost always wins—and usually by a wide margin. (Beginning this year, there will be only one vice president. Members voted for a referendum in the 2003 election that eliminated one of the two vice president positions.)

Nominating committees have had considerable difficulty in recent years coming up with a candidate to oppose a vice president nominated for president-elect. For nine consecutive years the senior vice president has been the victor in the president-elect contest.

Under the proposal, members would still have been able to run for president-elect by petition. The single-candidate option would not have applied to any other races for positions on the Board.

A majority of the Board registered opposition to the proposal. Former APA president Lawrence Hartmann, M.D., appeared to speak for many when he advised his colleagues against taking any step that could "distance" the Board from the APA membership. "We have to interest people in running and find ways of differentiating" among these individuals and their ideas for APA. He maintained that having an uncontested race for president-elect will dissuade many members from bothering to vote, aggravating an already waning interest in APA elections, judging from ballot totals.

Another former president, Daniel Borenstein, M.D., supported the proposal, stressing that there is "no evidence that contested elections have resulted in greater member participation or interest in [APA] elections."

Only four members voted for the uncontested-race proposal.

Policy Statement Adopted

The Board also voted to endorse a policy statement on universal access to health care coverage that says it is APA policy "to support universal access to health care, specifically including nondiscriminatory coverage of treatment for mental illness, including substance abuse, for all Americans. APA will advocate vigorously for this at local, state, and national levels." This was a modified version of an action paper that was passed by the Assembly.

With psychosomatic medicine gaining approval last year as the latest psychiatry subspecialty, the Board voted to back the formation of a Council on Psychosomatic

pleases see ***Board*** *on page 89*

DB Presidents Update Board On Local Concerns

Membership and money were on the minds of two district branch presidents who addressed APA Trustees last month.

At each Board of Trustees meeting, district branch (DB) presidents are invited to give a "state of the DB" talk to APA's elected leaders. At last month's meeting in Arlington, Va., one DB president departed from a commonly repeated refrain of DB presidents concerning declining membership by stating that his DB's membership actually increased in the last year—albeit it only slightly.

Ohio Psychiatric Association (OPA) President Mark Munetz, M.D., who described his organization as "one of the most active and progressive" DBs, told the Board that despite that encouraging uptick in membership, the organization was still facing declining dues revenue and continuing budget deficits. For 2004, Munetz said, the OPA had to raise dues to compensate for recent budget shortfalls, and DB leaders are worried about the consequences.

He noted that he and his colleagues are keeping a close eye on the state legislature, where psychologists are working to have a prescribing-privilege bill introduced.

The issue of psychologist prescribing was not a "what if" for the other DB president who addressed the Trustees.

Bruce Hinrichs, M.D., heads the DB in New Mexico, the only state that has passed a law allowing psychologists to prescribe psychoactive drugs without first graduating from medical school.

He noted that a state-level committee is in the final stages of deciding on how to implement the prescribing law, which was passed two years ago. The state's psychiatrists are troubled by the likely shape of the new law after the recommendations by the two psychiatrists on the committee were almost entirely rejected by the rest of the committee members. Only one of their 26 recommendations made it into the final series of implementation recommendations.

On the membership front, Hinrichs pointed out that his DB has seen a major reduction in its membership since 1995. Today its membership of 149 represents just 42 percent of New Mexico psychiatrists. ■

APA Leads Expanded Effort To Boost Research Funding

APA's Academic Consortium strengthens its advocacy for increased federal funding of psychiatric research and addictions through new partnerships.

BY CHRISTINE LEHMANN

APA joined with several new partners at its annual Academic Consortium meeting in Washington, D.C., last month to advocate with one voice for increased federal funding of psychiatric and addictions research.

APA Medical Director James H. Scully Jr., M.D., told *Psychiatric News*, "We are working to increase our efforts on behalf of psychiatric research by expanding the consortium to include organizations of leading researchers."

He continued, "Working together we can be more effective in advocating for the critically important need to support the research that has been so successful and holds such promise for improving the lives of our patients."

APA partnered with the American Academy of Child and Adolescent Psychiatry, National Alliance for the Mentally Ill (NAMI), American Association of Chairs of Departments of Psychiatry (AACDP), American College of Neuropsychopharmacology, Depression and Bipolar Support Alliance, and Society of Biological Psychiatry.

APA Praised

Representatives from these organizations who spoke to the consortium praised APA's decision to broaden the consortium.

Joel Silverman, M.D., who represented the AACDP, said at the consortium's meeting that academic departments of psychiatry are struggling to keep researchers due to a significant decline in research grants.

"We have almost dropped to the funding levels of the 1980s." said Silverman, chair of the department of psychiatry at Virginia Commonwealth University's School of Medicine.

"One glimmer of hope is an amendment by Sen. Arlen Specter [R-Pa.] to the Senate Budget Resolution for Fiscal 2005 approved by the Senate last month," said Silverman. The measure calls for a 7.6 percent increase over last fiscal year in the budget of the National Institutes of Health (NIH). This would add another $1.3 billion to President Bush's requested $764 million increase for NIH in Fiscal 2005, according to APA's Department of Government Relations (DGR).

Mental Illness Research Underfunded

Raymond DePaulo, M.D., the Henry Phipps professor and chair of psychiatry and behavioral sciences at Johns Hopkins University, mentioned that federal research on mental illness, including substance abuse, continues to be underfunded compared with other medical illnesses like diabetes or cancer.

President Bush requested only a 2.6 percent over last year's budget in the Fiscal 2005 budget proposal for the National Institute of Mental Health (NIMH) and the National Institute on Alcohol Abuse and Alcoholism. He requested a 2.8 percent increase over last year for the National Institute on Drug Abuse.

DePaulo was optimistic that funding will increase for research on depression and other mental illnesses much as it has for cancer. "Depression and other psychiatric illnesses are misunderstood and underfunded in the way cancer research was in the late 1960s. There was a stigma about cancer, a lot of misinformation, and only a few poorly understood treatments."

DePaulo continued, "With the development of molecular biology, scientists have learned about the very nature of cancer, and now we have several distinct cancer-fighting strategies besides surgery. At Johns Hopkins, we have gone from four cancer specialists in 1968 to several hundred on the faculty today."

Brain Disease Findings Expected

DePaulo predicted the next big story in biomedicine will be that of brain diseases, including the most severe psychiatric illnesses. "Over the next 33 years, we can change the course of psychiatric illnesses as we did with cancer since we declared war on it in 1971," he said.

Progress will be driven by advances in genetics, brain imaging, and the molecular biology of brain mechanisms. "Investment in these basic sciences is the first step. It is important for enthusiasts and critics alike to realize that the translation of the molecular discoveries into effective treatment strategies for the psychiatric illnesses will take a concerted effort and time," De Paulo said.

APA and its consortium partners support a 10 percent increase in the NIH budget to continue promising research and transform findings into treatment, according to DGR. APA and most of its consortium partners also support a 10 percent increase for the federal institutes for research on mental illness, including addictive disorders.

NAMI would like to see the NIMH budget increased by 12 percent in Fiscal 2005 and by $1 billion over a five-year period, said Laura Lee Hall, director of NAMI's Policy Research Institute, at the consortium meeting. That and other recommendations are in a new report by NAMI released in February (see page 18). ■

Advocating for Patients and the Profession

This year, after a brief hiatus, APA members returned to Capitol Hill as constituent grass-roots lobbyists as part of APA's Advocacy Day 2004. The 37 members who came to Washington, D.C., for the event received an intensive two days of information and training, culminating in a Capitol Hill lobbying blitz on March 23.

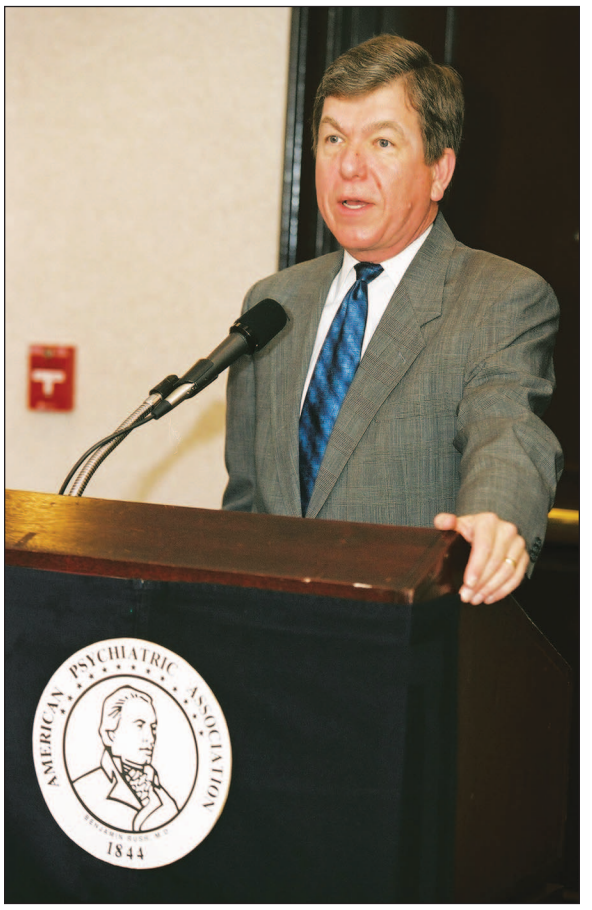
APA targeted four key committees of the U.S. Congress: the House committees on Energy and Commerce, Ways and Means, and Education and the Workforce; and the Senate Subcommittee on Substance Abuse and Mental Health Services.

These committees have jurisdiction over a host of APA strategic priorities, including nondiscriminatory coverage of mental illness treatment, Medicare's discriminatory 50 percent coinsurance for outpatient psychiatric services, and confidentiality of patient medical records. Thus, APA participants targeted for their visits the senators and representatives who have a direct say on legislative matters of concern to psychiatrists and their patients.

Advocacy Day participants were primarily district branch legislative representatives and officers from the states whose congressional delegations are represented on the targeted House and Senate panels.

Participants were joined by several APA leaders, including APA President Marcia Goin, Assembly Speaker Prakash Desai, Speaker-elect James Nininger, Trustee Patrice Harris, Council on Advocacy and Public Policy Chair Jeremy Lazarus, Committee on Government Relations (CGR) Chair Tom Noyes, CGR Vice-Chair Dudley Stewart, Committee on Public Affairs Chair Mary Helen Davis, and APA-*PAC* Chair John Wernert III (all M.D.s).

TOP: Michael Koch, M.D., and Anna Vander Schraaf, M.D., review APA issue briefs before delivering "the message" to Capitol Hill. MIDDLE: Jeremy Lazarus, M.D., describes APA's new Division of Advocacy. BOTTOM: Captane Thomson, M.D. (left), and Tom Noyes, M.D., listen to a presentation on lobbying Congress.



House Majority Whip Roy Blunt (R-Mo.) addresses Advocacy Day participants on the House agenda, the new Medicare law, and mental health issues.

Key House and Senate staff "insiders" briefed participants on pending legislation and policy issues. Staffers on hand included Dean Rosen, health policy director to Senate Majority Leader Bill Frist (R-Tenn.); Joel White, staff director of the House Ways and Means Health Subcommittee; Bridgett Taylor, key minority health policy staff to the House Energy and Commerce Committee; Liz Fowler, chief minority counsel for health to the Senate Finance Committee; Josh Sharfstein, M.D., minority staff professional to the House Committee on Government Reform; Michael Zamore, policy advisor to Rep. Patrick Kennedy (D-R.I.); Karin Hope, legislative director to Rep. Jim Ramstad (R-Minn.); and Geoffrey Laredo, policy fellow to the Senate Subcommittee on Substance Abuse and Mental Health Services.

Debbie Curtis, chief of staff to Rep. Pete Stark (D-Calif.), and Priscilla Ross, legislative director to Rep. Ben Cardin (D-Md.), provided helpful perspectives on lobbying "dos and don'ts" to help APA members sharpen their lobbying skills before heading to the Hill.

Participants also heard a keynote address from House Majority Whip Roy Blunt (R-Mo.), who holds the third-highest rank in the House GOP leadership and is responsible for ensuring that the legislative priorities of the House leadership pass the House floor.

Stu Rothenberg, editor of the "Rothenberg Political Report," also spoke, giving his assessment of the political climate in Washington and across the country.

Other highlights included a reception hosted by the APA*PAC*, which featured Reps. Grace Napolitano (D-Calif.) and Tim Murphy (R-Pa.), co-chairs of the House Mental Health Caucus.

APA's 37 Advocacy Day participants made a total of 141 House and Senate office visits—almost all in a single afternoon—meeting with key Hill health staff and with 36 House and Senate members.

One immediate impact of their visits is a record number of cosponsors now supporting the Mental Health Equitable Treatment Act in both the Senate (69 cosponsors) and the House (245 cosponsors). ■

TOP: Rep. Tim Murphy (R-Pa.) (left) receives a plaque from APA*PAC* Chair John J. Wernert III, M.D. BOTTOM: Rep. Grace Napolitano (D-Calif.) talks with participant Philip Margolis, M.D., at the APA*PAC* reception.

Reps. Murphy and Napolitano, APA*PAC* reception guests of honor and co-chairs of the Congressional Mental Health Caucus, reiterate the importance of constituent lobbying. Both received APA's Disinguished Leadership Award and an APA*PAC* check.

Committee Presents Annual State-of-the-Election Report

Each year APA's Elections Committee presents a report to the Board of Trustees summing up the campaign experience for the election that was just concluded. Below is the report for the 2004 election, presented at last month's Board meeting.

BY YVONNE B. FERGUSON, M.D.

The Elections Committee, in keeping with a recommendation approved by the Board of Trustees in 2001, reports on the campaign experience, including violations of campaign guidelines, after each election. The committee extends its thanks to all candidates for their participation in the election and their cooperation with the committee.

Following a practice established several years ago, the Elections Committee held a conference call with nearly all candidates in October 2003 to review the election guidelines and to answer questions. The committee also used ElectCom, the list serve set up for use by the committee and candidates to post questions and answers about the guidelines and the election process. We believe that both the conference call and the list serve continue to be useful tools in providing candidates with the information they need to comply with the guidelines and in minimizing the number of violations.

The Elections Committee is pleased to report that it encountered only minor violations of campaign guidelines in the course of the 2004 election campaign.

There were two instances in which members used APA list serves (an Area list serve and the Assembly list serve) for campaign purposes. The only APA list serve (including district branch list serves) that may be used for campaigning is Member-to-Member. The committee will consider a change in this guideline to clarify that Area list serves are not to be used for campaigning and to re-emphasize that Member-to-Member is the only APA list serve that can be used.

There was one instance in which a district branch newsletter published a news item of the candidacy of one of its members but included a sentence that crossed the line from biography to campaigning. The committee will consider including the district branch executives of the branches to which the candidates belong in the conference call prior to the election, since those are the district branches most likely to publish information on the candidates in their newsletters.

Lastly, a candidate's photo appeared in the *Daily Bulletin* of APA's Institute on Psychiatric Services. The candidate did seek clarification on whether the photo could appear, but the photo was printed before the issue could be resolved. The photo should not have appeared, but the candidate could not be held accountable for it.

The Elections Committee will meet in May to review the 2004 election experience and report any recommendations for changes in the guidelines to the Board in June. The committee welcomes feedback about any aspect of the election, from the ballot design to candidate campaigning. Comments should be e-mailed to Carol Lewis at clewis@psych.org. ■

Yvonne B. Ferguson, M.D., is chair of APA's Elections Committee. The members of the committee are Ronald Albucher, M.D., David Hodo, M.D., and David Wahl, M.D.

Former President Ewald Busse Dies

One of the founders and leading lights in the subspecialty of geriatric psychiatry dies at age 86.

Former APA President Ewald Busse, M.D., one of the pioneering figures in geriatric psychiatry, died March 7 in Durham, N.C. He was 86.

Busse was president of APA for the 1971-72 term. He was associate provost emeritus at Duke University and former dean of medical and allied health education at Duke. For 21 years beginning in 1953, Busse was chair of Duke's psychiatry department.

When Duke honored him in 1985 by naming its new geriatric center the E.W. Busse Gerontology Building, it acknowledged his status as one of the founders of the field of geriatric psychiatry. He was a founding director of the Duke Center for the Study of Aging and Human Development. In addition to APA, Busse served as president of the American Geriatrics Society, Gerontological Society of America, International Association of Gerontology, and the North Carolina Institute of Medicine.

Each year the North Carolina Division of Aging bestows the Ewald W. Busse Award for achievement in gerontological research.

Among his groundbreaking studies was the 25-year-long Duke Longitudinal Study of Aging, which identified factors that predict a longer life and marked a shift away from the traditional venue of nursing homes for studying factors associated with aging.

He is author or co-author of more than 250 scientific articles.

He was a member of both the Institute of Medicine and the National Academy of Sciences. ■

Institute Wants Residents And Their Research

Psychiatry residents are encouraged to share their research and participate in activities specifically for them at APA's fall Institute on Psychiatric Services.

BY STEPHEN M. THIELKE, M.D.

Are you a psychiatry resident who has research, ideas, or scholarly activities that you would like to share in a national forum? If so, then APA's 2004 Institute on Psychiatric Services, which is being held in Atlanta from October 6 to 10, can provide an exciting opportunity for you.

Stephen M. Thielke, M.D., is a 2003-05 APA/Bristol-Myers Squibb Fellow.

The institute provides an excellent opportunity for residents to meet experts and leaders in the field, as well as other residents, and to learn about innovative work from around the country.

This year's institute will feature five poster sessions that will make it easy for residents who are working on research projects to present their findings to a national audience.

In the past, roughly 90 percent of all poster submissions were accepted for presentation.

In addition to the poster sessions, the institute includes many other experiences of particular interest to residents, including leadership and career-development seminars, a residents-only "Meet the Experts" luncheon that provides an opportunity for informal consultation and networking, a residents-only welcoming reception, a full-day session on homeless mentally ill people, clinical discussion groups, and mentoring opportunities.

Residents who register before September 6 qualify for a reduced registration fee of $60. Training departments often pay for registration and/or travel if the resident is also presenting a poster.

The poster-submission deadline is June 1. Residents interested in submitting posters may obtain a submission form by calling APA's Answer Center at (888) 357-7924 or downloading one from APA's Web site at <www.psych.org/edu/ann_mtgs/ips/04/submissions/sf/index.cfm>. The completed submission form should be faxed to (703) 907-1090.

Further information is available by contacting Jill Gruber by phone at (703) 907-7815 or by e-mail at jgruber@psych.org. ■

Pardes Appointed

Herbert Pardes, M.D., president and CEO of New York-Presbyterian Healthcare System, has been named to the board of directors of the Markle Foundation, which funds the acceleration of the use of health care information technology.

Pardes is a former APA president and director of the National Institute of Mental Health. ■

VA Gets Insufficient Funds For PTSD Care, APA Testifies

APA's medical director tells Congress that the VA needs "to catch up" financially after years of declining resources for mental health services.

BY KATE MULLIGAN

APA Medical Director James H. Scully Jr., M.D., tells a House Appropriations subcommittee that VA research on mental illness, including substance abuse, is vastly underfunded in relation to the number of veterans who have such disorders.

"For too long, mental health care has not been a priority for the VA." So declared APA Medical Director James H. Scully Jr., M.D., to the House Appropriations Subcommittee on VA, HUD, and Independent Agencies.

Spending on mental health services has declined by 25 percent in inflation-adjusted dollars since 1996, he said. In that year, Congress passed PL 104-262, which mandated that the Department of Veterans Affairs "maintain capacity" to provide treatment for mental illness and other categories of disability.

Moreover, Scully said, "APA is concerned that VA mental health service delivery has not kept pace with advances in the field."

Those advances include intensive case management, access to substance abuse treatment, peer support and psychosocial rehabilitation, pharmacologic treatment, housing, employment services, and other supports to independent living.

Scully expressed particular concern about access to treatment for posttraumatic stress disorder (PTSD).

He said that the number of patients diagnosed with severe PTSD had increased 42 percent from 1996 to 2001, but expenditures to treat the disorder had increased by only 22 percent in the VA system.

Fifteen years ago, the VA Special Committee on PTSD urged that there be a PTSD clinical team at every VA medical center. Now, however, only about half of all VA medical centers have such teams.

"Many of the staff originally dedicated to PTSD services at those sites have long since been drawn off to other duties or lost to attrition," he said.

Scully commended members of the subcommittee for adding $25 million for PTSD treatment in Fiscal 2004.

But, he warned, "To catch up with the backlog of patients waiting for care and to keep pace with need, Congress should dedicate funding incrementally by $500 million from Fiscal 2005 to Fiscal 2009 for specialized treatment for veterans" who have mental illnesses, including PTSD and substance use disorders.

"APA is concerned that VA mental health service delivery has not kept pace with advances in the field."

Scully commended the VA for initiating eight Mental Illness Research, Education, and Clinical Centers (MIRECCs). The MIRECCs provide support for psychiatric research into severe mental illness.

He pointed out, however, that less than 9 percent of the VA health research budget is dedicated to mental illness and substance use, even though 35 percent to 40 percent of VA patients need mental health care.

Scully also reminded committee members that the VA has considerable "ability to translate progress in medical science to improvements in clinical care" because more than 60 percent of VA researchers treat veterans.

Scully is a Navy veteran with 12 years of experience in the Denver VA department of psychiatry.

Prakash Desai, M.D., chief of staff at the West Side Division of VA Chicago Health

please see ***VA Funding*** *on page 15*

OSLER (ORAL/WRIT)
1/4

SHEPPARD PRATT (GENERICO
1/4

WYETH AYERT SYMPOS (GRE-DEN)
1/2H BW

Medicare Trustees Warn Of Dire Fiscal Future

The new prescription drug benefit in the Medicare reform law is estimated to increase the total cost of Medicare by one-fourth when it begins in 2006.

BY MARK MORAN

The Medicare program will be broke in 2019, according to this year's report of the Medicare and Social Security trustees. The trustees state that Medicare's Hospital Insurance (HI) Trust Fund is projected to be exhausted in 2019, seven years earlier than had been projected in last year's report.

Further, the new Medicare Modernization Act (MMA) accounts for two years of the seven-year difference in solvency dates, according to the report.

Other factors cited by the trustees include higher spending and lower tax revenues in 2003 than projected (accounts for two years), associated assumption adjustments (1.5 years), improved data on the health status of beneficiaries in health plans (one year), and model refinements for estimating certain hospital payments (0.5 years).

The hospital insurance component of Medicare (Part A) was intended to be self-supporting—that is, it is financed through designated sources of income (primarily earmarked payroll taxes) rather than relying on general tax revenues. The supplemental medical insurance component (Part B) is not intended to be self-supporting; beneficiaries pay a monthly premium to participate, with general tax revenues covering the remaining costs.

But diminishing tax revenues and increasing costs are draining the coffers fast. And the Medicare reform law has created a new component (Part D) to fund the prescription-drug benefit. These benefits will increase the total cost of Medicare by an estimated 25 percent when they begin in 2006 and are projected to grow more rapidly than Part B costs, according to the trustees.

Part B spending is experiencing rapid growth—more than 10 percent in each of the last four years—with costs expected to nearly double over the next 10 years and to accelerate further as the first members of the baby-boom generation enter the program in about 2010, according to the report.

The Part B account ran a deficit of $10.3 billion in 2003, because the beneficiary premiums and general revenue financing were set before Congress acted to raise Medicare physician payments significantly, thereby increasing Part B costs over the scheduled financing. In 2004 the Part B account is again expected to run a deficit ($1.7 billion) because the beneficiary premiums and general-revenue financing were set before the MMA was enacted, further increasing Part B costs.

As a result, premiums and general revenues in 2005 and later will have to be adjusted upward significantly to match the higher level of costs.

"The projections shown in this report continue to demonstrate the need for timely and effective action to address Medicare's financial challenges—both the long-range financial imbalance facing the HI trust fund and the continuing problem of rapid growth in both HI and SMI [Supplementary Medical Insurance] expenditures," the report said.

The Medicare trustees are Treasury Secretary and Managing Trustee John W. Snow, Secretary of Health and Human Services Tommy Thompson, Labor Secretary Elaine L. Chao, and Social Security Commissioner Jo Anne B. Barnhart. Two other members, the public trustees, are appointed by the president, with Senate confirmation. The public trustees, John Palmer and Thomas Saving, serve four-year terms and represent the general public. Dennis Smith, acting administrator of the Centers for Medicare and Medicaid Services, serves as secretary to the board.

The report, "2004 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds," is posted at <www.cms.hhs.gov/publications/trusteesreport>. ■

Dems Want Bush to Explain Medicare Cost Discrepancies

Senate leaders have asked President Bush if anyone in his administration was aware of threats to dismiss the Medicare chief actuary if he released information on the administration's cost estimates.

BY MARK MORAN

Republicans on the House Ways and Means Committee have effectively put an end to demands by Democrats to investigate charges against the Bush administration for withholding from Congress the true cost figures for the historic Medicare reform legislation, known as the Medicare Modernization Act (MMA).

On the floor of the Senate last month, Minority Leader Tom Daschle (D-S.D.) quoted extensively from a report that appeared in the *Miami Herald* stating that the administration withheld cost estimates for the Medicare bill that were upward of $100 billion more than the $395 billion the Congressional Budget Office estimated the bill to cost in the first 10 years.

The story, picked up by other press outlets, cited an e-mail from the chief actuary for the Centers for Medicare and Medicaid Services (CMS) to colleagues stating that he was under threat of being fired if he released the higher estimates.

In response, Democrats on the Ways and Means committee had asked former CMS director Thomas Scully and White House aide Doug Badger to answer questions about when President Bush and other officials learned that prescription drug benefits included in the bill would cost about $150 billion more than Bush said he wanted to spend and why lawmakers were not given that information.

White House counsel Alberto R. Gonzales explained in a letter to committee chair Bill Thomas (R-Calif.) that Badger would not appear before the committee because of "long-standing White House policy" against having White House staff testify before Congress.

The charges, however, are still being investigated by the Department of Health and Human Services (HHS), while Democrats have requested civil and criminal probes, according to a report in the April 2 *Los Angeles Times*.

At the time of debate on the bill, a number of conservative House Republicans were vowing to vote against the bill if it cost more than $400 billion.

"I think this is one of the most reprehensible actions that I have seen since coming to Congress," Daschle said on the Senate floor. "I think we ought to bring this bill back for another vote. I think the House and the Senate deserve to have a vote based on all of the information, not just part of it. If this and perhaps other information was withheld, members of Congress were called to vote under false pretenses. They were called to vote without having the truth. On an issue with these repercussions, we have no other choice but to re-vote this issue. . . .

"As close as that vote was, in the dead of night, I think we owe it to the American people, we owe it to seniors, to reconsider these votes and question whether or not we can put in place some absolute guarantee that this will never happen again."

In a letter to President Bush, Daschle and Sen. Edward Kennedy (D-Mass.) asked President Bush to answer questions about the allegations.

"It is well known that the administration's legislative strategy was developed by a high-level White House task force including the secretary of HHS, the director of the National Economic Council, the director of the Office of Management and Budget, special assistants to the president, and the administrator of the Centers for Medicare and Medicaid Services," the senators wrote.

"It is inconceivable that this high-level group was not well informed about the actuary's cost estimate of the bill and the various policy alternatives considered during the course of negotiations with Congress. . . . Congress relied on those representations even while your administration's internal estimates viewed them as erroneous." ■

VA Funding

continued from page 12

Care System and speaker of APA's Assembly, praised Scully's testimony for its succinct identification of the resources needed. He also pointed out that many pressures compound that need.

Returning veterans from Iraq and the effect of state budget crises on the public mental health system tax the ability of the VA to provide quality care, as does the fact that many veterans are aging.

More specifically, Desai said, "When a steel mill recently shut down on the south side of Chicago, workers lost their jobs and insurance. Many came to the VA for health services."

The increasing number of people without insurance throughout the country is straining all components of the VA's health budget.

Scully's testimony is posted online at <www.psych.org/advocacy_policy/leg_res/apa_testimony/vaappropriations03252004.pdf>. ■

Not All Children Created Equal in ADHD Treatment

A number of serious consequences attend the underdiagnosis and lack of treatment of ADHD among African-American youth.

BY CHRISTINE LEHMANN

Members of the Congressional Black Caucus last month heard from psychiatrists about racial disparities in diagnosis and treatment of ADHD.

An estimated 3 percent to 5 percent of African-American children have attention deficit/hyperactivity disorder (ADHD)—the same rate as Caucasian children.

However, the similarities end there. ADHD in African-American youth has been studied far less than ADHD in Caucasian children, and African-American youth have less access to comprehensive mental health assessments leading to fewer diagnoses and less treatment. Even when ADHD is detected, African-American youth are less likely to be treated with appropriate medications, said child psychiatrist M. Christopher Griffith, M.D., in an interview with *Psychiatric News*.

Griffith, an assistant professor of psychiatry at Morehouse School of Medicine in Atlanta, participated in a panel presentation on ADHD in African-American youth last month on Capitol Hill. Two other psychiatrists participated—Marilyn Benoit, M.D., immediate past president of the American Academy of Child and Adolescent Psychiatry, and Rahn Bailey, M.D., chair of the National Medical Association Section on Psychiatry.

Two patient advocates with children diagnosed with ADHD rounded out the panel. Former U.S. Surgeon General David Satcher, M.D., spoke via video satellite.

The panel briefing was co-sponsored by Reps. Sheila Jackson Lee (D-Tex.) and Donna Christian-Christensen (D-V.I.) in partnership with the organization Children and Adults With Attention Deficit/Hyperactivity Disorder (CHADD). About 30 professional health care and patient advocacy groups including APA joined CHADD in co-sponsoring the briefing.

"This is one of several CHADD initiatives to increase cultural competency among mental health professionals and eliminate disparities in care for minority populations," CHADD Chief Executive Officer E. Clarke Ross said in a press release.

Griffith said that psychiatrists and mental health professionals have historically overdiagnosed African-American men as having severe mental disorders such as schizophrenia. A more recent trend is overdiagnosing African-American males with conduct disorder or oppositional defiant disorder and underdiagnosing ADHD in this population, said Griffith.

"The consequences for undiagnosed ADHD among African-American youth are significant including substance abuse, teen pregnancies, and occupational failures," said Griffith.

African-American children face significant barriers in obtaining a comprehensive mental health assessment, including stigma about mental disorders in their communities, lack of mental health coverage, and poorer quality of health care and mental

please see ***ADHD*** *on facing page*

Committee Chair Threatens Health Programs' Funding

Rep. Joe Barton (R-Tex.), chair of the House Energy and Commerce Committee, opened his first hearing last month by announcing that funding for health programs whose formal authorization has lapsed should be cut.

Barton replaced Billy Tauzin (R-La.) as chair of the powerful committee when Tauzin resigned in February as chair, according to the March 11 *Kaiser Daily Health Policy Report*.

Barton told Health and Human Services Secretary Tommy Thompson, the hearing's only witness, that a preliminary staff analysis identified 93 health programs that are receiving funding from appropriators without proper authorization, according to the policy report.

"I don't think that's a responsible practice. From my perspective, programs without authorization should not receive the same funding priority," said Barton in the report.

Numerous programs have lapsed authorizations at the National Institutes of Health, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Indian Health Service, according to the report.

Thompson agreed that programs should be reauthorized in a systematic way. However, Barton's suggestion met with disapproval from many of his congressional colleagues. Rep. Henry Waxman (D-Calif.) said, "I don't know what he's thinking. We'd be slitting our throats by saying 'don't fund these programs that we have not gotten around to reauthorizing,' " according to the report. ■

Rep. Joe Barton: "From my perspective, programs without authorization should not receive the same funding priority."

ADHD

continued from facing page

health treatment in general, Griffith said.

"Misinformation about the causes of ADHD or claims that it doesn't exist don't help parents seeking answers to their children's problems," said Benoit at the briefing.

Griffith said eliminating mental health care disparities among minorities will require a greater emphasis on the role of culture and race in medical school and residency training.

"In addition, we need to do a better job of attracting minorities into medicine, psychiatry, and research," Griffith said.

The press release "Experts Assail Undertreatment of ADHD in African-American Youth" is posted at <www.chadd.org>. ■

Health-Related Tax Breaks Favor Wealthy Workers

Tax benefits for health-related expenditures raise equity issues, according to two health care policy analysts.

BY KATE MULLIGAN

Tax benefits for health insurance favor those with higher incomes, according to an analysis in the February issue of the journal *Health Affairs*.

John Sheils, vice president of the Lewin Group Inc., and Randall Haught, a senior scientist there, estimate that the tax expenditure for health benefits in 2004 will be $188.5 billion in 2004.

They define the term tax expenditures as the amount of revenue that the federal government foregoes by exempting certain health benefits and spending from the federal income and Social Security taxes. Or, more simply, it is the amount of money the federal government loses because it grants certain health-related tax exemptions.

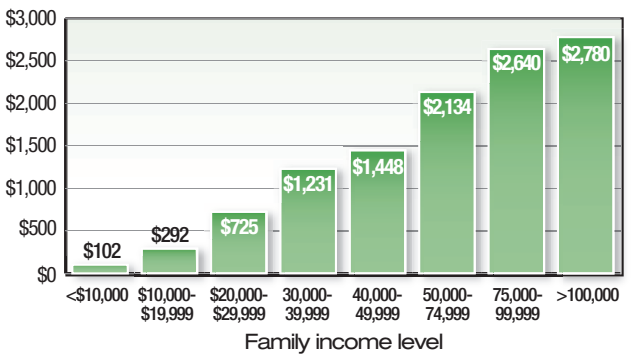
Those items include employer health benefit contributions for workers and retirees. For 2004 the authors estimated that employers will pay about 77 percent of the cost of employer-sponsored coverage. The value of these benefits is not taxable to the employees.

The authors noted, "It is important to understand that the tax expenditure for health benefits accrues to workers rather than employers."

Other items that help produce that $188.5 billion figure are tax deductions for out-of-pocket health spending that exceed 7.5 percent of adjusted gross income, health-benefit deductions for the self-insured, and reimbursement accounts through which out-of-pocket health costs can be paid in pretax dollars.

Federal Health Benefit Tax Expenditure Favors High-Income Earners

The average health benefit tax expenditure per family in 2004 will be $1,482. For those families with incomes of more than $100,000, it will be nearly twice that, while for those making less that $10,000, it will be less than 1/10th of the average.



Source: *Health Affairs*, February 25, 2004, Web exclusive

Sheils and Haught estimate that the average health benefit tax expenditure will be about $1,482 per family in 2004. However, the rewards of the tax exemption accrue largely to high-income groups (see chart above).

Families with annual incomes of $100,000 or more will gain an average of $2,780, but families with incomes of less than $10,000 will gain an estimated $102.

Only 28.4 percent of all tax expenditures in 2004 will go to families with incomes below $50,000, even though this group contains 57.5 percent of families in the United States.

The authors wrote that the "results raise important equity issues concerning the current distribution of tax benefits."

Given the fact that more than 43 million Americans are uninsured, the authors asked "whether it is appropriate that 26.7 percent of federal health benefits tax expenditures goes to the 14 percent of the population with the highest incomes."

The article, "The Cost of Tax-Exempt Health Benefits in 2004," can be accessed for a fee at <www.healthpolicy.org>. ■

PFIZER SYMPOS
(STAHL)
ISL 4C

Research-Funding Increases Said Key to Better Care

BY CHRISTINE LEHMANN

Dramatic improvements in patients' lives could be realized in the next 10 years if research was expanded and the treatment system reformed.

That was the conclusion of the National Alliance for the Mentally Ill's (NAMI) Task Force on Research convened by the NAMI Policy Research Institute last year in its new report, "Roadmap to Recovery and Cure."

The report, released in February, calls for a larger federal investment by Congress in the National Institute of Mental Health (NIMH). The institute was funded at $1.38 billion in Fiscal 2004. NAMI is recommending an increase of approximately 12 percent, or $200 million, over last year's funding level, according to Laura Lee Hall, Ph.D., staff director of the NAMI Policy Research Institute, at APA's Academic Consortium meeting last month (see pages 8 and 9).

"Continuing and expanding basic research advances and translating them into treatment development, as well as improving the implementation of existing effective treatments, were viewed as a public health priority by the task force," according to the report.

Achieving these goals requires a signifi-

please see ***Funding*** *on facing page*

New Private Hospital Fills Gap in City's MH System

For many in Detroit, a new psychiatric hospital slated to open there in late summer brings new meaning to the saying that when one door closes, another one opens.

BY DAVID MILNE

Mental health care officials in Detroit are optimistic that a new hospital planned to open there later this year will help fill the gap left by the closure of Northville Psychiatric Hospital, the state's largest hospital for mental health care and one of the last public mental health facilities in Detroit.

When Northville closed last May, it left hundreds of Detroit-area patients scrambling for care in hospitals around the state (*Psychiatric News*, February 7, 2003). The city lost almost half of its hospital beds for mentally ill people—from 1,965 in 1994 to 1,088 last year—during the administration of former Gov. John Engler (R).

The new 90-bed private hospital on Detroit's east side, known as the Circle of Life Health Care, will serve Wayne, Oakland, and Macomb counties. It will provide acute, short-term, long-term, and intensive care for 60 adults and 30 children and intake service for people who show up at the door.

The hospital is a project of a group of health care professionals and a Detroit real estate executive who saw a need for intensive therapy in a clinical setting after many of the hospitals for mentally ill individuals closed. The facility has already obtained a certificate of need from the state, a precondition to being issued a license. It must now get the approval of the Joint Commission on Accreditation of Healthcare Organizations after its visitation in August.

Relatives of patients who opposed the transfers and long distances they had to travel to see loved ones welcomed the new hospital as they consider visitations and important part of therapy.

"If the proposal for the new hospital is sound, the facility would be a much-needed resource, and it would be great to get people from this part of the state back into the area again for long-term care, instead of having to move hundreds of miles away," Mark Reinstein, Ph.D., president of the Mental Health Association in Michigan, told *Psychiatric News*.

"One of the potential problems, if this all gets off the ground, is what happens if service payers and managers refuse to use the facility or will use it only for acute stays but nothing longer," he added.

Hubert C. Huebl, M.D., president of NAMI Michigan, said he was glad to hear of the first mental health hospital in years to be opened privately.

"I'm all for it because there is a need for long-term beds," he told *Psychiatric News*, "but many questions need to be answered."

These include whether the hospital will take Medicaid patients and whether insurance companies will be willing to pay the hospitals' rates for people who need long-term care.

Huebl thinks it would be a good idea for the hospital to provide subacute care, such as that offered by a 24-bed unit in Mt. Clemens. He is trying to get similar ones developed in Wayne County, which includes Detroit, to accommodate about 100 people who are now housed in Kalamazoo Psychiatric Hospital and elsewhere. He is also communicating with Hope Network, which is based in Grand Rapids.

After complaints from people with mental illness and their relatives, Gov. Jennifer Granholm (D) appointed a special commission to study the need for inpatient care for people with mental illness since most of the state's psychiatric hospitals have been closed. Michigan has closed more hospitals than any other state during the last 20 years.

Three members of the Michigan Psychiatric Society serve on the commission: Tom Carli, M.D., Michelle Reid, M.D., and Rajiv Tandon, M.D. ■

Funding

continued from facing page

cant increased investment in research involving serious mental illnesses. This wasn't defined in the report but applies to all mental disorders that can be disabling and chronic, Hall told *Psychiatric News*.

To expedite improved treatment and recovery from serious mental illnesses, the task force made several recommendations. Among them:

- Significantly increase funding of NIMH's basic, clinical, and health services research focused on serious mental illnesses.
- Congress should direct NIMH to prioritize research on serious mental illnesses and apply the "NIH Roadmap for Medical Research" to serious mental illnesses.
- Continue and expand clinical-trial networks focused on serious mental illnesses.
- The NIMH and the Substance Abuse and Mental Health Services Administration should improve their public communication of research advances relevant to practice and patient outcomes.
- Increase training and support of researchers and mental health care professionals.

The report, "Roadmap to Recovery and Cure," is posted online at <www.nami.org/sciencetaskforce>. More information on the the "NIH Roadmap for Medical Research" is posted online at <http://nibroadmap.nih.gov>. ■

RENAISSSANCE ED
1/4

MCCLEAN HOSPITAL
1/4

GLAXO SKB SYMPOS
(VIGUERRA)
1/2H BW

WYETH EFFEXOR

P4C

Psychiatric Patients Fall Victim to Medicaid Crisis

Issues of health care access, in many forms, plague states that have slashed their budgets for Medicaid and other public services.

BY KATE MULLIGAN

Satya Chandragiri, M.D., urged mental health advocates to absorb an important lesson from Oregon's experience with the impact of state budget cuts.

"We have a public health crisis, rather than a crisis in access to mental health services," he said. "Unless we take that broad view, people will say this is just a problem for mental health, and stigma will isolate us."

Chandragiri is the medical director of Eastern Oregon Psychiatric Center, a 60-bed public hospital in Pendleton, and a board member of the American Association of Community Psychiatrists (AACP).

He joined AACP's President Jacqueline Feldman, M.D., and board member Kenneth Thompson, M.D., in the second of a series of conversations with *Psychiatric News* about public mental health services at the state level. (The previous conversation on this topic appeared in the March 5 issue.)

Feldman holds the Patrick H. Linton Endowed Professorship in the department of psychiatry and behavioral neurobiology at the University of Alabama at Birmingham (UAB) and is executive director of the UAB Community Mental Health Center.

Thompson is an associate professor of psychiatry and public health at the University of Pittsburgh and a Soros Foundation Physician Advocate Fellow.

Satya Chandragiri, M.D.: "If you are 'near poor' and not eligible for Medicaid, decide not to have a psychosis in Oregon."

Crisis Unfolds in Oregon, Alabama

Oregon gained national attention when the state cut prescription drug and mental health benefits in 2003 for approximately 100,000 poor people. Officials also cut funding for items such as "crisis" mental health services, supported-employment programs, and residential-treatment services (*Psychiatric News*, April 4, 2003).

"We are seeing the painful results that were predicted last year," Chandragiri said.

The total number of staff of the community mental health centers (CMHCs) has decreased by about 25 percent since July 2003 because of layoffs and attrition.

Law-enforcement personnel and emergency rooms have become "first responders" because of the elimination of funding for crisis mental health services, which had been provided by CMHCs.

But, said Chandragiri, those added responsibilities come at a time when budgets for law enforcement are also being slashed. In rural areas, particularly, there might be no "responder" at all.

Admissions went up from 215 in 2002 to 293 last year at his 60-bed hospital.

"When the budget crisis started, many patients received letters saying services would be terminated. That caused a panic, and some patients decompensated. There was a reprieve of sorts, but by then they had been hospitalized. Then layoffs at the clinics began, and other mental health staff left because of the financial instability," he said.

For those who are poor but not eligible for Medicaid, the situation can be worse than it is for Medicaid beneficiaries.

Chandragiri said, "If you are 'near poor' and not eligible for Medicaid, decide not to have a psychosis in Oregon."

Alabama, too, is being buffeted by a state budget crisis.

Feldman said that voters turned down an "innovative tax package from our courageous Republican governor [Bob Riley]" last September. The failure to pass the tax initiative set off a period of intense budget cutting.

Those cuts come at a time when deficits in the Medicaid program are projected to increase fourfold, from $50 million in Fiscal 2004 to $200 million in Fiscal 2005.

Approximately 25 percent of the state's residents receive Medicaid benefits, which is a reflection of the extent of poverty in the state, said Feldman.

Officials Consider 'Draconian Measures'

Some changes already have occurred. "Each patient receiving Medicaid benefits used to be assigned to a primary care doctor who would coordinate services. It was a marvelous program," said Feldman. But it has been terminated.

State officials are considering "Draconian measures" to control use of prescription drugs, she said.

They have proposed that Medicaid patients be limited to only seven prescriptions a month or to four prescriptions for brand-name drugs and unlimited prescribed generic drugs.

Feldman, who is on the state's Pharmacy and Therapeutic's Committee for Medicaid, pointed out that patients with mental illness experience high comorbidity with

other types of illness.

She said she asked officials, "Who will decide what medications to cut off? Have you read the literature about what happens when access is denied?"

Both Feldman and Chandragiri emphasized the difficulties of accessing care in rural areas.

"If you live in an urban region, chances are good that you will have some way of accessing mental health care, even if it is only medication," said Feldman.

Jacqueline Feldman, M.D.: "Who will decide what medications to cut off?"

"But if you live in a rural area, you could be totally out of luck."

Pendleton, which has a population of 16,000, is located in a rural area of eastern Oregon. Chandragiri said, "In my county, there were three psychiatrists in private practice. One has retired, one is planning to retire, and the third psychiatrist will not accept new patients."

No one is available to provide psychiatric consultation to primary care physicians and consultation/liaison services to the local general hospitals. Primary care physicians feel "pretty helpless" when they need a psychiatric consultation and fear that a patient could enter a suicidal crisis, he added.

Chandragiri urged greater attention to workforce and access problems in rural areas and suggested that representatives of APA district branches visit those areas in their states to collect testimony and observe problems firsthand.

Lull Before the Storm?

Thompson said that Pennsylvania had "come back from the brink" after a showdown between Gov. Edward Rendell (D) and the state legislature over budgets for human services and education.

He noted that shrinking state resources easily could result in a "zero sum game" in which mental health advocates and other residents believe they must choose between use of resources for human services and for education.

"Which side are you going to be on?" he asked. "A bad education system can make mental health problems worse."

Although the impact of the state's budget problems on mental health is not as stark as in Oregon and Alabama, efforts to implement concepts in the President's New Freedom Commission on Mental Health report have been stymied by lack of resources.

"It's difficult to plan without security about future funding," he said.

Budget cuts to the Department of Housing and Urban Development, for example, have translated at the state and local levels into less access to housing for those with mental illness.

What Can Be Done?

The three participants in the conversation with *Psychiatric News* emphasized the importance of receiving timely information of various kinds.

"I was asked recently at a meeting how advocates in other states are responding to Medicaid cuts," said Feldman.

Kenneth Thompson, M.D.: "It's difficult to plan without security for future funding."

"We are all juggling many, many things, and we could benefit by having that kind of information in some easily accessible form."

She commended the improvements in APA's Web site and finds the state and federal advocacy updates useful and timely.

Both Feldman and Thompson said that regionally targeted alerts from APA would help in their advocacy.

Chandragiri urged that APA place issues such as psychologist prescribing privileges and mental health parity in the larger context of "how long does it take to get care? What can we do to improve access to care?"

Links to the Advocacy Action Center and newsletters with information on state budget cuts and other issues affecting community psychiatry can be accessed on the homepage of APA's Web site at <www.psych.org/advocacy_policy>. ■

BMS SYMPOS (TAN-DON)
ISL 4C

Patient-Safety Strategies Can Reduce Suicide Risk

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

BY JACQUELINE M. MELONAS, J.D., R.N., M.S.

The safety of patients with suicidal behaviors is of utmost concern for the clinicians who evaluate and treat them. It is a hard reality that sometimes in the course of treatment a patient commits suicide. A suicide is a devastating event for all involved—the patient's family, friends and community, the treatment team, and the treating psychiatrist. Also, unfortunately, patient suicide and suicide attempts are the most frequently identifiable cause of lawsuits against psychiatrists.

Improving patient safety for those at risk of suicide is an extremely important goal when the personal, professional, and dollar cost of patient suicide is so high. APA's Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors, published in a supplement to the November 2003 *American Journal of Psychiatry*, is an essential and comprehensive tool for improving patient safety and offers recommendations to help psychiatrists assess and treat adult patients with suicidal behaviors.

This brief article focuses on one risk management strategy that has the potential to support patient safety and reduce professional liability exposure. The methodology that has been set out by experts for improving patient safety involves identifying errors, analyzing the causes of preventable errors, and developing better processes and systems to prevent those problems and errors in the future. This is also the description of the risk management process. The five-step risk management process is described below to present the reduction of lethal means and methods of self-harm as a patient-safety measure for patients with suicidal behaviors.

Step 1: Identify current and potential risks

The potential for self-harm by a patient with suicidal behaviors exists throughout his or her evaluation and treatment. The risk that a patient will commit suicide is highest when the patient is most vulnerable and least able to protect himself or herself, for example, at discharge from the hospital. The accessibility of lethal means and methods of self-harm increases the risk of self-destructive behaviors.

Step 2: Evaluate risk (frequency and severity)

Data from the National Center for Health Statistics as of 1998 show that firearms are used in 57 percent of suicides. Other methods are suffocation (18.7 percent), poisoning, including medications (16.6 percent), and falls (2 percent).

Research has shown that increased rates of suicide are linked to the presence and accessibility of a lethal means of self-destruction, and that "40 percent to 50 percent of households have a firearm inside the home," according to the Department of Health and Human Services (HHS) 2001 report, "National Strategy for Suicide Prevention: Goals and Objectives for Action."

Since the use of medications has become a centerpiece for psychiatrists in the treatment of mental illness, it is highly likely that patients with suicidal behaviors will be prescribed medication and will have access to potentially lethal medications. They may also have access to medications prescribed for comorbid somatic conditions or to the medications of family members or significant others. The use of alcohol or illegal substances in conjunction with prescribed medications increases lethality.

Suicide is a low-frequency/high-severity event. However, the presence of firearms or stockpiled medication increases the risk of a suicide occurring (frequency). The presence of those means also tends to keep the probable lethality of efforts high (severity). Reducing these risks requires a systematic approach.

Step 3: Choose a risk management strategy

Evidence shows that restricting access to lethal methods of self-harm can be an effective strategy to prevent self-destructive behaviors for some individuals, according to the HHS report. These are some risk management strategies for reducing the risk of the most frequent methods of suicide: firearms and poisoning:

- During evaluation of patients with suicidal behaviors, inquire about suicide plans and whether a method has been considered. Find out about methods used in any prior suicide attempts.
- Inquire whether firearms are available to patients with suicidal behaviors.
- Educate patients and significant others about the risk of accessibility of firearms.
- Instruct patients and significant others about restricting access to firearms and properly securing or removing firearms.
- When prescribing for patients with suicidal behaviors, the decision about type and amount of medication should reflect the ex-

please see ***Patient Safety*** *on page 94*

Jacqueline M. Melonas, J.D., R.N., M.S., is vice president of risk management at Professional risk management Services Inc., manager of the APA-endorsed Psychiatrists' Professional Liability Insurance Program.

Soldiers Say Combat Stress Second to Personal Stress

A mental health team assigned to help soldiers in Iraq deal with trauma and stress finds that soldiers need more help with mental health issues related to interpersonal problems than they are getting.

BY CHRISTINE LEHMANN

Because U.S. Army Combat Stress Units in Iraq are situated close to where soldiers are serving, those who need mental health care can get it quickly.

In old war movies, soldiers were always men who had sweethearts back home. Occasionally, a soldier would receive a painful "Dear John" letter that underscored the downside to Army life.

Some things have changed since then—women are soldiers in today's Army, and soldiers are just as likely to serve in peacekeeping missions as they are in war action.

But marriage is still a domestic casualty of Army deployments, and Dear John or Dear Jane letters are still received by soldiers, according to Maj. Robert Cardona, a U.S. Army psychiatrist assigned to a combat stress control (CSC) unit, the 98th Medical Detachment, in Mosul in northern Iraq for the past year. Cardona was interviewed online by *Psychiatric News* last August and again last month. He recently returned home to Fort Sill, Okla.

In the past year, four CSC medical detachments, including the 98th, and one CSC company of nine combat stress teams were in Iraq. A typical CSC has three prevention teams, each with a psychiatrist, a social worker, and mental health technicians, Cardona explained. Another common element is a restoration team consisting of a psychologist, occupational therapist, and clinical nurse practitioner, he said.

The units' mission involves supplementing the work of division and hospital psychiatrists and mental health professionals, said Cardona.

More than 100,000 U.S. soldiers have been sent to Iraq during the past year, often not seeing their family for one year. More replacements will be sent this year to help keep peace during the shift to self-rule in Iraq. Cardona described northern Iraq as a combat zone in which U.S. soldiers are targets of daily mortar attacks by hostile forces.

Most soldiers are aware of combat stress reactions from their training and from Army education campaigns. Many sought help from the 98th CSC before being sent back home, Cardona said.

"These soldiers were concerned that they would become violent and injure a family member or someone else back home. They were aware that [several] soldiers at Fort Bragg had become violent after returning from duty in Afghanistan a few years ago," he pointed out.

Relationship Issues Intensified

Between 60 percent and 90 percent of the 1,500 soldiers seen in the past year by the 98th medical detachment and by division psychiatrists had interpersonal problems. "The real stress results from family, personal, and work interpersonal issues that are intensified in deployment to a combat zone," Cardona said.

Soldiers with major depression can be successfully treated in the field in most cases. Minor depression and anxiety are more common, and treatment consists of antidepressant medication and/or a series of brief cognitive-behavioral therapy interventions, according to Cardona.

Several Developed Psychosis

"Early in the deployment, we used medication to treat a handful of individuals who experienced their first psychotic or manic episode," he noted.

About 8 percent of soldiers treated by

please see ***Soldiers*** *on page 94*

Economic Empowerment Improves Women's Mental Health

Efforts to improve women's mental health internationally should consider the social, biological, educational, and cultural aspects of their lives, said experts at the second World Congress on Women's Mental Health last month.

BY CHRISTINE LEHMANN

Women's mental health is highly impacted by their access to employment, food, education, health care, and resources for economic development, said an international group of women's health experts last month.

When denied access to these services and resources, women become more vulnerable to physical and sexual violence, psychiatric disorders, and psychological distress, said psychiatrist Donna Stewart, M.D., at the Second World Congress on Women's Mental Health last month in Washington, D.C. Stewart is president of the International Association for Women's Mental Health.

Women worldwide are more likely to live in poverty, be illiterate, have AIDS, and be victimized by partner violence than are men. Female genital mutilation affects between 100 million and 140 million women in Africa, Asia, and the Middle East, said Stewart, who also chairs the World Psychiatric Association's Section of Women's Mental Health.

Men outnumber women in many third-world countries including India, China, Pakistan, and Saudi Arabia. This may be due to discriminatory practices against females including selective abortion, infanticide, malnourishment, excessive injuries, and receiving less treatment for medical illnesses, said Stewart.

Donna Stewart, M.D.: While "[m]odern treatments play an important role in managing depression in individual women, we also need to address the context of women's lives."

"Women's right to quality reproductive health services are an intrinsic part of their basic right to health and well-being," she emphasized. When women have access to birth control and other family-planning options, including safe abortions, they can plan when and if they want children and pursue educational and employment opportunities, said Stewart.

"Yet there is a wide disparity in the availability of contraception, access to safe abortions, and safe childbirths worldwide," she pointed out. Half a million women die from pregnancy-related complications annually, she added.

Education of women was declared a human right in the 1995 Beijing Platform for Action, said Stewart, and is considered the key to empowering women economically and socially.

As a model of a successful initiative, she described the transformation of an entire village in Guatemala she has visited for 30 years through economically empowering the local women.

"Several years ago, a poor Indian village in the western highlands of Guatemala experienced extreme deforestation and drought. Crops were lost, and seeds became unattainable," explained Stewart.

The villagers were deprived of food and income and became demoralized. The men began to drink alcohol heavily, beat their wives, and stopped productive work.

"The women also became demoralized and stopped taking care of their families. Schoolteachers left, infants died from diarrhea, and violence was rampant," she said.

A small multinational group heard about the village's problem and decided to give the women a small loan. The women started a weaving cooperative, since weaving was a skill they already knew.

"Their beautifully dyed cotton fabrics caught the attention of high-end designers, who marketed them throughout America and Europe," said Stewart.

The women earned enough income from their weaving to build latrines and health clinics and to buy seeds and some fields back. The infant mortality rate dropped, and the children went back to school. The women established five more weaving cooperatives with their income.

"The men didn't dare beat their wives because the women had the money now," Stewart explained.

The community is now a model for other communities, said Stewart. "One small loan made an enormous difference. When you think about making a difference that will improve women's mental health, think about other choices for women besides SSRIs."

Stewart added that she sometimes recommended SSRIs but knew that they were not the ultimate solution to the global problems affecting women's mental health. Although she acknowledged that "modern treatments play an important role in managing depression in individual women, we also need to address the context of women's lives," she said.

Information about the International Association for Women's Mental Health is posted online at <www.womenmentalhealth.com>. ■

PFIZER GEODON ORAL

P4C

PFIZER GEODON ORAL

P4C

PFIZER GEODON ORAL

P4C

PFIZER GEODON ORAL

P4C

Advocates Urge Greater Focus On Perils of Inhalant Use

An increasing number of middle-school students do not grasp the danger of inhalants, which may be a factor in the upward trend in inhalant use.

BY EVE BENDER

Inhalant usage rates rose among middle-school students between 2002 and 2003, according to data presented in March at a press conference held by the National Inhalant Prevention Coalition (NIPC) in Washington, D.C. The data prompted renewed calls for prevention of inhalant use from top government officials.

"The use of inhalants is a big concern since these products are legal and can result in irreparable brain damage and death," said Charles Curie, the director of the Substance Abuse and Mental Health Services Administration (SAMHSA).

"Make no mistake—SAMHSA, in collaboration with our partners gathered here today, will continue to educate the families of America on the dangers of inhalants."

Inhalants are the only class of drugs for which usage rates are higher among middle-school students than high-school students. They include fumes from nearly 1,000 household products, such as rubber cement, correction fluid, spray paint, hair spray, and paint thinner.

Synergies, a nonprofit corporation based in Austin, Tex., founded the NIPC in 1992 to raise awareness about inhalant use.

According to the 2003 Monitoring the Future Survey, inhalant use among eighth-grade students rose from 7.7 percent in 2002 to 8.7 percent in 2003 *(Psychiatric News*, February 6).

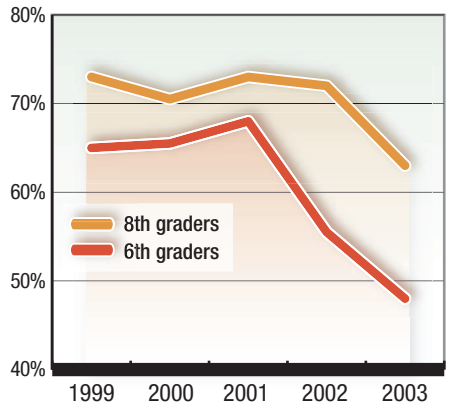
In comparison, just 3.9 percent of seniors reported using an inhalant in 2003.

According to the 2002 National Survey on Drug Use and Health, which is published by SAMHSA, 10.5 percent of youths aged 12 to 17—more than 2.6 million youngsters—have used one or more types of inhalants during their lives.

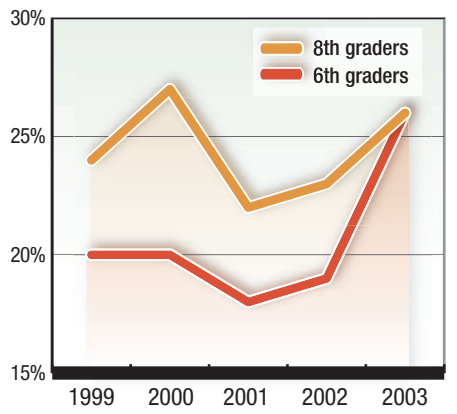
Ignorance Can Kill

The Partnership for a Drug-Free America finds that abuse of inhalants among sixth and eighth graders has increased as the awareness that the practice can kill has decreased significantly.

Agree that sniffing or huffing things to get high can kill you



Ever tried



Source: Partnership for a Drug-Free America, 2004

Harm Not Perceived

Part of the problem is that many middle-school students don't believe that inhalants can be fatal or even harmful, according to Stephen Pasierb, president and CEO of the Partnership for a Drug-Free America.

Decreased perceptions of risk have often preceded increased usage rates. Pasierb shared results from the 2003 Partnership Attitude Tracking Study. This study, which used a sample of 7,270 seventh- through 12th-grade students, was conducted by Roper ASW Inc. between April and June 2003. For the first time, the 2003 survey also included a sample of 1,140 sixth-grade students.

The data revealed that in 2001, 68 percent of sixth graders agreed with the statement, "Sniffing or huffing things to get high can kill you." By 2003, just 48 percent of sixth graders agreed.

A similar but less substantial drop was noted for eighth graders: 73 percent agreed with the statement in 2001 compared with 63 percent last year.

The survey also showed that inhalant use increased among sixth graders between 2001 and 2003 from 18 percent to 26 percent. Eighth-grade use increased from 22 percent to 26 percent in the same period.

"The youngest kids are displaying the weakest attitudes and the sharpest inclines in use," said Pasierb. "We're at a point where this could become a worsening trend."

Easily Obtained, Deadly Consequences

That may translate into an increasing number of inhalant-related injuries and deaths, according to Nora Volkow, M.D., director of the National Institute on Drug Abuse. Inhalants, she told attendees, are substances that, in addition to being widely avail-

please see ***Inhalant Use*** *on page 96*

ASHP
1/4

PSYPREP1/4

WYETH SYMPOS (KRISHNAN)
1/2H BW

Can Analytic Skills Cool World's Hot Spots?

What happens when the world of psychiatry and psychoanalysis interfaces with the world of international politics? A psychiatrist-psychoanalyst from the Turkish area of Cyprus and now affiliated with the University of Virginia has some answers.

BY JOAN AREHART-TREICHEL

Vamik Volkan, M.D., an emeritus professor of psychiatry at the University of Virginia and director of the university's Center for the Study of Mind and Human Interaction, has had one foot in the world of psychiatry and psychoanalysis and the other foot in the world of international politics for a number of years now.

Through his center, and also through committee work at APA, he has had contact with leaders and diplomats from various countries, notably former American President Jimmy Carter, former Soviet President Mikhael Gorbachev, and former Palestinian leader Yasser Arafat. Volkan has also helped bring leaders and diplomats from enemy countries and enemy backgrounds together so that they can resolve their differences.

"Sometimes I sit in a room where big shots scream and yell at each other," he admitted at the American Psychoanalytic Association meeting held in New York City in January.

Also at the meeting, Volkan discussed some of the points analysts should consider if they are going to become embroiled in international affairs, some of the analytic techniques he has used to bring enemies together, and some of the insights he has learned about the psychodynamics of large groups.

For example, analysts, like other people, have their prejudices. Volkan said. For instance, Freud was prejudiced against Turks and Mongols. Thus, if an analyst decides to get embroiled in international politics, he or she needs to keep in mind that analysts are no more objective than other people are when it comes to international relations, Volkan said.

Bringing Enemies Together

How do you bring diplomats from two enemy countries together? You fly them to a neutral place; divide them into small groups; tell them that you, the analysts, are in charge; and then say: "Tell us what is on your minds," Volkan advised.

If a diplomat from one country claims that he or she knows what the other country wants, kindly tell that person to stop speaking for the other country, Volkan added.

Do not try to get diplomats from hostile countries to be too "lovey-dovey" with each other because it is too artificial and will backfire, he said. It is better when a psychological border remains between the two groups before they sign an agreement.

Group Psychodynamics Come Into Play

Every large group has had, at some time, a traumatic event—say, a loss of land or a loss of prestige, Volkan explained. This loss leads the group to feel humiliated, shamed. If the group does not properly mourn this loss, it may pass its feelings about it onto future generations, and the trauma becomes the group's "chosen trauma." A chosen trauma not only solidifies the group's identity but may be used by the group to resist negotiations with its enemy.

Regression in an individual involves a return to some of the psychological expectations from an earlier stage of human development. It is a response to stress or trauma. "Imagine going home after a hard day at work, sitting in front of a fire on a

please see ***Hot Spots*** *on page 90*

Vamik Volkan, M.D., who has long been involved in international politics, greets Mexico City psychoanalyst Cora Ann Dobbs, Ph.D., at the American Psychoanalytic Association meeting in New York City.

Psychiatry Continues to Rebound, Match Results Show

Psychiatry has seen an explosion in the neurosciences and an invigoration and sharpening of the use of the psychotherapies, drawing medical students to the profession.

BY MARK MORAN

A total of 641 U.S. senior medical school graduates matched into general psychiatry residency programs around the country this year.

That figure is up from 597 in 2003, according to the National Residency Matching Program.

In addition, 338 students—including mostly international medical graduates (IMGs), Canadian students, and U.S. seniors who had graduated in previous years—also filled slots this year, for a total of 979 students entering PGY-1 general psychiatry residency positions this summer.

"I believe the exciting advances in neuroscience are in part responsible for this increase," said Deborah Hales, M.D., director of APA's Division of Education and Career Development. "Research on the genetics of mental illness was named the number-two scientific 'breakthrough of the year' by *Science* magazine in its December 19, 2003, issue. In addition, the humanistic aspects of psychotherapy and the autonomy of psychiatric practice are other reasons we can hope to see this increase continue."

An undetermined number of IMGs are also likely to enter psychiatry programs outside of the match to fill the remaining slots, said Area 4 Trustee Sydney Weissman, M.D., who has for years monitored match figures and workforce issues in psychiatry.

A small number of U.S. graduates entered double- and triple-board psychiatry programs this year: internal medicine/psychiatry (14); pediatrics/psychiatry/child psychiatry (18); and family medicine/psychiatry (9).

Selected Match Results
1994-2004

	1994	1997	2002	2003	2004
U.S. Medical Students					
General Psychiatry	438	462	564	597	641
General Surgery	928	883	762	667	885
Family Practice	1,850	2,340	1,389	1,226	1,185
Pediatrics	1,404	1,596	1,583	1,596	1,611
General Internal Medicine	2,551	2,820	2,738	2,590	2,602
Anesthesiology	542	173	597	606	575
Radiology	306	381	655	692	691
PGY-1 Residency Selection Total Non-U.S. Senior Students in Psychiatry Match	238	372	343	319	338
Total Matched PGY-1 Psychiatry	676	834	907	916	979*

*Total includes Canadians, IMGs, osteopaths, and seniors who graduated in years prior to 2004

Weissman said the trend continues to be up for the profession. He noted, however, that the mental health needs of the American population far outstrip the psychiatric workforce, and that colleagues in primary care and other branches of medicine are likely to have to continue to pick up the slack.

"We have made significant progress in recruitment from 1998, when only 428 U.S. seniors selected PGY-1 general psychiatry residencies," Weissman said. "We must remember that without the support of our medical colleagues, psychiatrists cannot deliver all of the medically informed mental health care in our country. We must assure that medical education for medical students and nonpsychiatric residents contains a critical core of psychiatric knowledge and training."

The annual match is conducted by the National Resident Matching Program (NRMP), a private, not-for-profit organization established in 1952 to provide "an orderly and fair mechanism" to match the preferences of applicants to U.S. residency positions with the preferences of residency program directors for those applicants.

This year 25,246 applicants participated in the match, a 5.3 percent increase in participation since 2003. For the first time ever, more than 20,000 matches were made to first- and second-year residency positions, according to the Association of American Medical Colleges.

James Taylor, president of the NRMP, was quick to point to the increase in match participants as an indicator of the overall vitality and importance of the match, in light of a lawsuit filed by some medical students and residents claiming that the match process violates antitrust laws *(Psychiatric News*, June 7, 2002).

"The notable increase in applicants and residency positions this year indicates a high level of support and a continued confidence in the fairness of the match," Taylor said. "It also once again demonstrates how important the match is to medical education and sends a clear message to those who want to dismantle the process."

Data from each year's match serve as an indicator of career interests among residency applicants and a prognostic indicator of the future physician workforce profile. Here are some highlights from this year's match:

• U.S. medical school seniors filled 84.8 percent of the available first-year general surgery positions, up from 82.7 percent last year. This marks the second successive year

please see ***Match*** *on facing page*

Psychiatrist Wins Prestigious Medical Education Award

Extraordinary energy, commitment, and innovation are among the reasons that psychiatrist Carlyle Chan, M.D., won a teaching award from the Accreditation Council for Graduate Medical Education.

BY JOAN AREHART-TREICHEL

Each February, for three years now, several resident program directors have received Parker J. Palmer Courage to Teach Awards from the Accreditation Council for Graduate Medical Education (ACGME).

The awards, which are given to residency program directors whom the ACGME considers outstanding, are named after Parker J. Palmer, Ph.D., who developed a program to renew the spirit of teachers and who wrote the book *The Courage to Teach*.

One of the 10 program directors to be honored in February was a psychiatrist—Carlyle Chan, M.D., professor and vice chair for education and informatics in the department of psychiatry at the Medical College of Wisconsin.

"There are hundreds if not thousands of excellent, dedicated program directors in all specialties across the country," Chan told *Psychiatric News*. "I am honored to have been one of the 10 selected this year and am grateful for the recognition for doing the job I love to do."

"I actually gave Dr. Chan his role of director of residency education and recommended all of his promotions and helped mentor his career," Harry Prosen, M.D., former chair of psychiatry at the Medical College of Wisconsin, and one of the individuals who nominated him for the award, told *Psychiatric News*. "I was always struck with his enthusiasm, energy, organizational skills, and his demanding that his ideas have a fair hearing."

"Carl is extraordinary for his creativity in, commitment to, and energy for innovative education," Laura Roberts, M.D., chair of psychiatry at the Medical College of Wisconsin and one of the persons who nominated Chan for the award, added. For instance, she noted, he started teaching evidence-based psychiatry years before it became known by that name. He also helped initiate and develop the Psychotherapy Center, one of only a few such psychotherapy training clinics in the country. In addition, Chan was one of the first program directors nationwide to computerize residency administration by introducing the use of personal digital assistants to record resident patient logs and provide a mobile psychopharmacology database to aid in patient care and safety, Roberts said.

When Chan was at the Parker Palmer Awards ceremony in February, did he sense that he and the other nine awardees share some of the same techniques for teaching medical residents? "I got the impression that we all share the same dedication and enthusiasm for teaching, but not necessarily the same techniques," he told *Psychiatric News*. "There are many ways to teach, for instance, lecturing, small-group discussions, individual supervision, among others. However, the teacher must in some way connect with his or her student. This is, in part, what Parker Palmer writes about in his book *The Courage to Teach*."

Last year, a psychiatrist received a Parker Palmer Award as well. He was Gene Beresin, M.D., director of child and adolescent psychiatry residency training at Massachusetts General Hospital and McLean Hospital.

More information about the Parker J. Palmer award is posted online at <www.acgme.org/palmerAward/palmerMem.asp>. ■

Match

continued from facing page

of an increase in the surgery fill rate for U.S. seniors.

- 78.8 percent of PGY-1 family practice residency positions were filled, up 2.5 percentage points from last year. U.S. medical school seniors matched to 41.4 percent of those positions, a slight decrease from 2003. Family practice programs have experienced a steady decrease in the percentage of U.S. medical school seniors matching to their positions since 1996.
- Pathology programs continue to experience a higher percentage of positions filled through the match, a trend that began four years ago. This trend also holds true for U.S. medical school senior applicants to these programs; the percentage of PGY-1 pathology positions filled by U.S. medical school seniors has almost doubled since 2000 (to 61.2 percent in 2004).

Weissman said this year's match figures generally reflect the continuing resurgence of specialty medicine after a period of decline in the 1990s.

A combination of scientific and career-lifestyle factors continues to drive the choices medical school graduates make, he observed.

"I believe there are two important variables," Weissman said. "The first relates to the specific aspects of a medical discipline, its science, and how it is uniquely practiced. In psychiatry we have seen an explosion in the neurosciences and an invigoration and sharpening of our use of the psychotherapies.

"The second variable relates to the standing of the discipline in the eyes of medicine and our society, income patterns, and the impact of practice on lifestyles. I do not see many significant shifts in the near future in the broad area defined by this variable." ■

Curriculum Aims to Improve MH Care of African Americans

Understanding and appreciating diversity within the African-American population is just one of the ways psychiatry residents can be more effective when treating African-American patients.

BY EVE BENDER

Educating residents and faculty about the cultural issues, strengths, and mental health risk factors shared by diverse groups of African Americans is necessary to ensure quality psychiatric care for African-American patients.

This was the message presented at a workshop titled "Designing an African-American Curriculum From the Inside Out" that was held at the meeting of the American Association of Directors of Psychiatric Residency Training in New Orleans last month.

"The majority of psychiatrists treating African-American patients are not from the same ethnic group or culture, and that is why training in this area is so important," said Timothy Benson, M.D., chief resident in substance abuse at the Massachusetts General Hospital (MGH)/McLean residency program in adult psychiatry.

Benson, along with colleagues Marketa Wills, M.D., chief resident in international and public psychiatry at the MGH/McLean program, and Anthony Chambers, Ph.D., a clinical fellow in psychology at the MGH psychology internship program, are developing a model curriculum to help psychiatrists in training and faculty provide more effective treatment to African-American patients.

From left: Anthony Chambers, Ph.D., Marketa Wills, M.D., Timothy Benson, M.D., and Kathy Sanders, M.D., are working together to create a curriculum to teach psychiatry residents and faculty to work more effectively with African-American patients.

Benson pointed out that African-American patients have historically received short shrift where psychiatric treatment is concerned.

African Americans, he said, are at an elevated risk for developing mental illness, compared with other ethnic groups, due in part to high rates of poverty and exposure to violence.

However, African Americans may be more hesitant to seek care due to a pronounced—and well-founded—mistrust of the mental health system due to "clinician bias and stereotyping, which have impacted the type and quality and care provided to African Americans," he said.

For instance, several studies show that African-American patients are overdiagnosed with psychotic disorders such as schizophrenia and underdiagnosed with mood and anxiety disorders, Benson pointed out.

He also cited research showing that when compared with white youth, African-American youth are four times as likely to be restrained during a bout of aggressive behavior.

Benson and his colleagues have some help in devising a model curriculum—in 2001, members of APA's Committee of Black Psychiatrists created a template for instructing psychiatry residents on the treatment of African-American patients.

Crucial elements of the curriculum include an exploration of the heritage of African Americans, according to Wills. The legacy of the "middle passage, in which African youth were trapped, abducted, and packed as cargo in ships, is still a part of the identity of black youth today," she said.

The curriculum is also designed to help residents become more aware of the heterogeneity of African Americans as a group—there are substantial differences in socioeconomic status, skin color, sexual orientation, and language that must be taken into account when treating these patients.

Other learning objectives include understanding the impact of belief systems and acculturation on the impact of the therapeutic relationship and identifying issues and conflicts within the trainee's own culture, Wills said.

In addition, training on diagnosis and treatment issues as they pertain to African-American patients is included in the committee's recommendations. "African-American women who are depressed may display an increased level of irritability, which might be considered normal in terms of their cultural sterotypes, but for that patient, it may be a sign of mood decompensation," Wills said.

The need for a curriculum dealing with the treatment of African-American patients is clear, but some residency training directors and faculty may be reluctant to teach the subject, according to Chambers.

Chambers cited the results of a survey

please see ***Curriculum*** *on page 85*

FOREST LEXAPRO

P4C

FOREST LEXAPRO

P4C

FOREST LEXAPRO

P4C

FOREST LEXAPRO

P4C

FOREST LEXAPRO

P4C

FOREST LEXAPRO

P4C

FOREST LEXAPRO

P4C

FOREST LEXAPRO

PBW

APA Renews Revenue Sharing

BY PRAKASH DESAI, M.D.

Revenue sharing with APA's district branches and state associations (DBs/SAs) is back. I am delighted to report that the Board of Trustees has decided, at the urging of the Assembly, to reinstitute a plan for sharing nondues revenue that had to be shelved a year ago. The reinitiated project will invite DBs/SAs to submit requests for innovative ideas and special needs, such as membership recruitment, public awareness, and infrastructure improvements.

The idea of APA's sharing revenue with the DBs/SAs arose with the realization that while APA has substantial nondues revenues, the DBs/SAs depend almost exclusively on dues revenue.

In 2000 the Board of Trustees set aside $752,000 to be distributed in 2001 to the DBs based on their membership totals. When the program began, it was stipulated that the amount set aside, if any, in subsequent years would depend on APA's fiscal health. The project and the formula were extensively discussed in the Assembly and with the Assembly Executive Committee.

For 2002 the amount to be distributed was only about $280,000—that is, $5,000 for each DB except in the three states (California, New York, and Missouri) with multiple DBs. In those states the SA was to receive the $5,000 and determine how to apportion it among its DBs. The Board stipulated that as a condition of receiving the money, the DBs/SAs were to evaluate the program and inform the Board of how the funds were spent.

In 2001 most DBs/SAs used the funds primarily for educational meetings and operating expenses; a small number replenished their reserves.

The revenue-sharing plan was a boon to many district branches, especially smaller ones whose capacity to raise revenue through dues is limited by their membership numbers. Some DBs/SAs assumed that the stream of revenue from APA would continue and built the expected funds into their budgets. With declining membership, the fiscal situation for several small DBs became precarious.

The Board, worried about APA's balance sheet as the 2003 budget was finalized, did not set aside revenue-sharing funds for that year.

At the fall 2003 Area 7 meeting, the dire straits of several small DBs in that Area came to light. Dr. Al Vogel, the Area 7 trustee, and I were both in attendance, and at the Board's next meeting in December, we requested that the Board make $50,000 available immediately to those DBs whose scarce resources were not enough to maintain even a basic infrastructure.

The Board approved our motion and asked Dr. Jay Scully, APA's medical director, to proceed with determining which DBs were in the most serious need and issue small grants immediately. Seven DBs received grants of $3,000, and one a grant of $1,500.

Additionally, we asked the APA Budget Committee to consider allocating $100,000 for 2004, which the Board later approved.

At the same time the Board appointed a work group consisting of me as chair and other Board members, namely, Dr. Don Langsley, chair of the Committee on DB and SA Relations; Dr. Jack Bonner, chair of the Budget Committee; Drs. David Fassler, Anne Sullivan, Michelle Riba, Angela Harper, and Al Vogel; and from the APA staff, Dr. Scully, Therese Swetnam, and Linda Hughes.

Our task was to come up with criteria and a methodology to determine how to assist DBs/SAs in need of immediate assistance. It was stressed that we should explore functions that the central office could take over from the DBs/SAs that might not only save precious revenue, but also might provide economies of scale.

At the Assembly's fall 2003 meeting, there was further discussion of the plan to share nondues revenue, and after some heated and passionate arguments, the Assembly approved a resolution asking the Board to appropriate a sum of $280,000 and make $5,000 available to each DB or, in the three states with multiple DBs, to the SA.

At the Board meeting a few weeks later in December 2003, I raised the Assembly's action for consideration. After much debate, the Board voted to appropriate the $280,000, which was to be distributed in 2004, but disagreed with the Assembly's plan to distribute the same amount to each DB/SA.

The Board also asked the work group I chair to refine criteria for distributing the funds so that they could be targeted to specific needs and projects.

The reinstitution of the revenue-sharing plan also revealed that several DBs had failed to submit the required paperwork to qualify for the original 2002 revenue distribution, though most of them have since supplied the documentation that APA had requested.

The work group is still ironing out details of the distribution criteria and will have recommendations to present to the Board at its June meeting. We have sent out a survey to the DBs/SAs to help us assess how best to assist them. Once the criteria for evaluating DB/SA revenue-sharing requests are finalized and approved, I hope that we will receive imaginative proposals to use these funds to strengthen both APA and the DBs/SAs. ■

APA Works to Reduce Care Disparities

BY FRANCIS LU, M.D.

April is "Minority Health/Disparities Month." As chair of APA's Council on Minority Mental Health and Health Disparities, I appreciate the opportunity to share with you important new developments in this area for mental health and APA. I hope these thoughts may stimulate your thinking and activity in this area. Finally, I want to challenge our thinking to broaden beyond disparities related to race and ethnicity to those related to gender, sexual orientation, age, religion/spirituality, among other factors.

Two landmark reports have clearly placed the elimination of disparities in mental health care as a major objective for the country. Most recently, the 2003 report of the President's New Freedom Commission on Mental Health proposed that this country transform its mental health system by focusing on six aims; one of these is to eliminate disparities in mental health services. Two specific recommendations in this area are to "improve access to quality care that is culturally competent" and "improve access to quality care in rural and geographically remote areas."

Second, the 2001 supplement to the "Surgeon General's Report on Mental Health," titled "Mental Health: Culture, Race, and Ethnicity," clearly documented the disparities in mental health care for ethnic minorities in terms of access, quality, and outcomes. It also noted that ethnic minorities are grossly underrepresented in psychiatric research. These disparities impose a greater disability burden on individuals from the four ethnic minority groups. The 2004 APA Institute on Psychiatric Services, chaired by Gloria Pitts, D.O., will have the theme "Mental Health Disparities in the Community."

Furthermore, the 2002 Institute of Medicine's (IOM) "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare," made similar recommendations for health care in general after a comprehensive review of the literature. The IOM pointed to multiple causes for these disparities even beyond insurance, including clinician bias, patient factors, and the health care system itself. It called for action along system design, training, and research fronts to tackle these many causes.

APA has supported efforts to reduce disparities in several important ways. As APA president, Richard Harding, M.D., appointed the Steering Committee for Eliminating Disparities in Access to Psychiatric Care, soon after the surgeon general gave a plenary talk about the 2001 report at APA's fall component meetings in September of that year. Co-chaired by Altha Stewart, M.D., and Dale Walker, M.D., the steering committee was charged with recommending specific actions that APA could take to implement the report's findings. Its draft report will be presented in a component workshop at APA's 2004 annual meeting on Wednesday, May 5, at 9 a.m.

Second, the 2003 report titled "A Vision for the Mental Health System," written by a task force chaired by APA Vice President Steven Sharfstein, M.D., included as one of its 12 goals: "Mental health care should be readily available for patients of all ages, with particular attention to the specialized needs of children, adolescents, and the elderly. Unmet needs of ethnic and racial mi-

please see ***Viewpoints*** *on page 48*

Internet Resources

Minority Health and Health Disparities Month: www.omhrc.gov/omh/whatsnew/2pgwhatsnew/special128a.htm

"Achieving the Promise: Transforming Mental Health Care," New Freedom Commission on Mental Health, www.mentalhealthcommission.gov/reports/reports.htm

"Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda," Health and Human Services' Office of Minority Health, www.omhrc.gov/clas/

"Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups," Center for Mental Health Services, www.mentalhealth.samhsa.gov/publications/allpubs/SMA00-3457/default.asp

"Mental Health: Culture, Race, and Ethnicity," U.S. Surgeon General, www.surgeongeneral.gov/library/mentalhealth/cre/default.asp

"Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," Institute of Medicine, www.iom.edu/report.asp?id=4475

Francis Lu, M.D., is a professor of psychiatry at the University of California at San Francisco and chair of the APA Council on Minority Mental Health and Health Disparities.

Readers are invited to submit opinion pieces on issues facing psychiatry for possible publication in this column. They may be on an original topic or in response to previous "Viewpoints" articles. Those interested should contact Ken Hausman at *Psychiatric News* at (703) 907–7861; e-mail: KHausman@psych.org.

Psychiatrists, Employers Partner To Improve Workers' MH Care

Private employers finance and influence more than 50 percent of the health care economy. And while they may not like mandates, they do have an interest in the health of their employees.

BY MARK MORAN

Psychiatrists, insurers, and employers in Pittsburgh are in the early stages of an effort to improve recognition and treatment of depression at the workplace.

APA, the Pittsburgh chapter of the Pennsylvania Psychiatric Society, and city employers hope to improve treatment, lower costs, and heighten productivity through a program launched by the Pittsburgh Regional Health Initiative (PRHI). PRHI is a consortium of individuals and organizations that provide, purchase, insure, and support health care services in the region. Partners include clinicians, hospitals, insurers, large- and small-business health care purchasers, corporate and civic leaders, and elected officials.

Local and national leaders say the effort points to some heightened awareness on the part of business leaders about the importance of untreated depression and substance abuse in the workplace.

"Business people in Pittsburgh really recognize the importance of treating depression," said psychiatrist Alan Axelson, M.D., medical director for behavioral health services at HighMark Blue Cross/Blue Shield of Western Pennsylvania.

Program Integrates Care

He told *Psychiatric News* that PRHI has focused attention on specific disease conditions that affect worker performance and employer health costs including, recently, depression and diabetes. The two conditions have much in common, he said.

"These are two chronic diseases that are parallel in terms of what we need to do to improve current standards of care and to engage patients as active partners in their care and treatment," he said.

Axelson said Highmark has brought its primary care and specialty care networks together, doing away with the mental health carveout of the past, to facilitate integration of care between primary and specialty care. Meanwhile, it has collaborated with local employer Pittsburgh Plate Glass (PPG) to improve recognition of depression in the workplace.

"PPG has been working with Highmark to educate its employees about mental health issues, to develop work-site initiatives around the identification and destigmatization of depression, and to get patients to have appropriate expectations of their primary care physicians," Axelson told *Psychiatric News*. "That means employees should expect their primary care doctor to screen regularly for depression and bring the subject up themselves."

Axelson said Highmark is also working with PPG to inform occupational health nurses employed by the company about depression.

Psychiatric Input Key to Effort

PPG Medical Director Alberto Columbi, M.D., told *Psychiatric News* that the input of local psychiatrists is vital.

"We are trying to translate knowledge given to us by experts into action at the work site," he said. "We are not trying to create occupational psychiatry, but to facilitate access to existing services. Our role is to increase awareness of depression, combat stigma, and provide our employees with knowledge about treatment resources."

Columbi continued, "Specialists can help in providing guidelines to be followed by primary care physicians, provide support for difficult cases, and help in the rehabilitation and return to function and work of affected active employees. They can also provide work-site talks to increase awareness, reduce stigma, and familiarize the public with the principles of early recognition and early treatment and rehabilitation of depression. The work-site interventions can be organized directly with the employer, while clinical interventions can be organized through the health plan."

Norman Clemens, M.D., who is chair of APA's Business Initiative and visited the city on behalf of APA, said the Pittsburgh effort is in its early stages but represents the kind of collaboration that is essential.

"APA feels the Business Initiative is vital because private employers finance and influence more than 50 percent of the health care economy," he said. "Employers, like insurers, hate mandates. But unlike insurers, they have an interest in the health of their employees. They have proved to be responsive to data showing the bottom-line value of mental health care in enhancing productivity and retention of their employees and reducing disability, absenteeism, and the high utilization of medical care that often accompanies insufficiently treated psychiatric disorders. Depression, anxiety disorders, and substance use disorders are especially costly to employers." ■

"We are not trying to create occupational psychiatry, but to facilitate access to existing services."

Olanzapine Gets Warning For Use in Elderly

Regulators warn that olanzapine may not be the best antipsychotic medication choice for elderly patients with dementia.

BY JIM ROSACK

Eli Lilly and Co., working with regulators in several countries, has warned physicians that its best-selling antipsychotic medication olanzapine (Zyprexa) appears to be associated with a threefold increase in risk of cerebrovascular accidents (CVAs) in elderly patients with dementia.

In April 2003 Janssen Pharmaceutica issued a similar warning for its popular antipsychotic risperidone (Risperdal).

Researchers do not have a clear understanding of what mechanism may be underlying the link between these medications and increased risk of CVAs. Some psychopharmacologists have postulated, however, that the link could be due to both drugs' effects on serotonin. Serotonin has long been known to be active in blood-vessel constriction and dilation. However, no research has been published that clarifies the link.

Neither of the two second-generation antipsychotics is indicated for the treatment of behavioral disturbances in elderly patients suffering from dementia; however, both are commonly prescribed off label to calm aggression and agitation, as well as dementia-related psychosis in elderly, institutionalized patients.

The new olanzapine warning is the result of a pooled analysis of five clinical trials of the drug in elderly patients who have psychosis related to Alzheimer's disease, vascular dementia, or mixed dementia. The efficacy of olanzapine was not established in these trials.

In all, 15 patients of the 1,178 randomly assigned in the trials to receive olanzapine suffered CVAs (1.3 percent), compared with two patients out of the 478 randomly assigned to placebo (0.4 percent). This finding represents just over a threefold increase in CVA risk. For the subgroup of patients who had vascular dementia, there was a fivefold higher likelihood of experiencing a CVA. In all, four patients died while taking olanzapine, compared with one on placebo.

In consultation with the U.S. Food and Drug Administration, Lilly has added the following warning language to the Zyprexa label:

"Cerebrovascular Adverse Events, Including Stroke, in Elderly Patients with Dementia

"Cerebrovascular adverse events (e.g., stroke, transient ischemic attack), including fatalities, were reported in patients in trials of olanzapine in elderly patients with dementia-related psychosis. In placebo-controlled trials, there was a significantly higher incidence of cerebrovascular adverse events in patients treated with olanzapine compared with patients treated with placebo. Olanzapine is not approved for the treatment of patients with dementia-related psychosis."

Updated safety information for olanzapine is posted online at <www.zyprexa.com/common_pages/hcp_safety.jsp>. ■

viewpoints

continued from page 46

norities require urgent attention."

The Work Group to Actuate the Vision Statement, chaired by immediate past president Paul Appelbaum, M.D., has been working this year on specific recommendations (see page 3 and April 2 issue).

Third, APA has successfully recruited a director for the Department of Minority and National Affairs. She is Annelle Primm, M.D., an associate professor of psychiatry at Johns Hopkins University, who will be an important voice within APA on this issue (see page 1).

With eliminating disparities as the eventual goal, increasing workforce diversity and increasing cultural competence are seen by many as important means, among others, for achieving that goal. For example, the Institute of Medicine recently issued "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce" in which it stated that increasing racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students, among many other benefits *(Psychiatric News*, March 19*)*.

In *Defending Diversity: Affirmative Action at the University of Michigan* (University of Michigan Press, 2004), Patricia Gurin and her colleagues present clear evidence for the educational value of diversity. The importance of cultural competence can now be seen at the system level in such documents as in the 2000 "Culturally and Linguistically Appropriate Services (CLAS) Standards of the HHS Office of Minority Health" and the 2001 "Cultural Competence Standards in Managed Mental Health Care Services of the Center for Mental Health Services."

APA's Council on Minority Mental Health and Health Disparities believes that the important work to date that has focused on ethnic minority groups should now be broadened to look at the disparities related to other critical demographic factors, especially when they intersect. We hope APA and its membership will continue to engage these issues for the health and mental health of all. ■

ANNUAL MEETING EXHIBITORS GUIDE
P4C

ANNUAL MEETING EXHIBITORS GUIDE

P4C

ANNUAL MEETING EXHIBITORS GUIDE

P4C

GLAXO SYMPOS (MUSKIN)
1/2H 4C

HS--APA EXHIBITS
1/2H 4C

PASS THE BOARDS
1/4

MED UNIV OF SC
1/4

WYETH SYMPOS (COHEN)
1/2H BW

Researchers Backtrack On Autism, Vaccine Link

It has been six years since the first study suggesting a causative link between the MMR vaccine and autism was published. The study is again making headlines and stirring up controversy.

BY JOAN AREHART-TREICHEL

In 1998 British gastroenterologist Andrew Wakefield, M.D., and his colleagues published a study in the *Lancet* that was going to shake up both the medical research community and society at large.

The study included only 12 children with autism, but had two important findings. One was that all 12 had intestinal problems, suggesting a link between autism and bowel disease. The other was that parents of eight of the 12 children reported that their youngsters had shown signs of autism after getting the measles, mumps, and rubella (MMR) vaccine, implying a link between autism and the vaccine.

The latter finding, along with subsequent reports from Wakefield and various colleagues or from press statements issued by Wakefield, prompted a number of parents of autistic children to blame their children's autism on the MMR vaccine (*Psychiatric News*, September 7, 2001). It also prompted some legislators to hold hearings on the subject (*Psychiatric News*, June 7, 2002), and even led to the rates of immunization falling in both the United Kingdom and the United States.

Now the 1998 study is again making waves in the medical research world and in the public arena.

Research Conduct Criticized

Last February 22, some serious allegations of research misconduct were leveled against the study and its authors by the *Sunday Times*, a major London newspaper.

One of the allegations was that the children who were reported in the *Lancet* study were also part of a project led by Wakefield and funded by the Legal Aid Board—a pilot project to investigate grounds for pursuing a multiparty legal action on behalf of parents of allegedly vaccine-damaged children—and that this information was not disclosed to the *Lancet* editors. Another allegation was that before the results were reported in the February 1998 paper, they were passed to lawyers and used to justify a multiparty legal action—an action of which the *Lancet* editors were also unaware.

Thus, in the March 6 *Lancet*, considerable space was devoted to the allegations, as well as to statements by Wakefield and two other study authors about those allegations, to a commentary and statements by *Lancet* editors about the allegations, and to a statement by 10 of the 12 authors of the study.

The statement, which one might view as a partial retraction of the study results, or at least as a retraction of an interpretation of the study results, said: "The main thrust of [the February 1998] paper was the first description of an unexpected intestinal lesion in the children reported. . . . While much uncertainty remains about the nature of these changes, we believe that it is important that such work continue, as autistic children can potentially be helped by recognition and treatment of gastrointestinal problems. We wish to make clear that in this paper no causal link was established between MMR vaccine and autism as the data were insufficient. . . ."

> **"It is important to realize that temporal associations are not necessarily causal."**

Autism Expert Responds

"I have had a chance to review the commentary and correspondence from the *Lancet* regarding the partial retraction of findings from the 1998 Wakefield paper," Fred Volkmar, M.D., a professor of child psychiatry at Yale University and an autism authority, told *Psychiatric News*.

The paper "has been the source of great concern to parents and clinicians alike," he said. "The Wakefield, et al., paper was heavily publicized by the media, or at least certain parts of the media; subsequent negative reports that questioned this finding have been much less extensively covered.

"In the context of all the furor that this paper has caused, there is a significant danger that scientific discussion gets lost. In particular, it is the case that a small number of children with autism do have an apparent developmental regression; this is an important topic and deserves further research. As appears to have been the case in this study, however, it is important to realize that temporal associations are not necessarily causal," Volkmar emphasized.

So where does medical research currently stand on a possible causal link between the MMR vaccine and autism? Some additional studies on the subject have been conducted, Volkmar said, and none of them has come up with positive findings. Yet "the problem with negative studies," he conceded, "is that it is hard to prove the negative."

Thus, the controversy on the MMR vaccine and autism is probably not over.

The statements and commentary in the March 6* Lancet *are posted online at <www.thelancet.com/journal/backissue/vol363/iss9411/contents>. Click on the statement or commentary of interest. ■

AMERICAN PROFESSIONAL AGENCY

P4C

AJP
1/4

HS--ISS CALL FOR SUBMIS-
SIONS
1/4 4C

HS--APF SUPPORT 1/2H 4C

JANSSEN RISPERDAL CONSTA

P4C

JANSSEN RISPERDAL CONSTA

P4C

JANSSEN RISPERDAL CONSTA
P4C

JANSSEN RISPERDAL CONSTA

P4C

JANSSEN RISPERDAL CONSTA
P4C

JANSSEN RISPERDAL CONSTA

P4C

JANSSEN RISPERDAL CONSTA
P4C

Brain Receptor Suggests New Anxiety-Treatment Target

A brain receptor for the pituitary hormone vasopressin seems to be involved in anxiety and social recognition. It may provide a new strategy for treating social and affective disorders.

BY JOAN AREHART-TREICHEL

Besides participating in blood pressure control and helping the body retain water, the pituitary hormone vasopressin also seems to play a role in learning, memory, and social behaviors. Evidence for such involvement goes back to the pioneering work of Dutch scientist David de Wied during the 1960s.

But which of the three known receptors for vasopressin—V1a, V1b, or V2—might mediate vasopressin's influence on learning, memory, and social behaviors?

Isadora Bielsky, a graduate student in behavioral neuroscience at Emory University, and coworkers decided to explore this question by knocking out one of these receptors—the V1a receptor—in male mice and then comparing their learning, memory, social recognition, and anxiety behavior with that of mice with the receptor.

The mice without the receptor performed comparably to the control mice on learning and memory tests, they reported in the March *Neuropsychopharmacology*. However, compared with the control mice, the mice without the receptor exhibited markedly reduced anxiety behavior and a profound impairment in social recognition.

Given these findings, Bielsky and her team suggested that the V1a receptor "may provide a novel potential pharmacological target for social and affective disorders, including autism and anxiety disorders."

This report "adds to a growing body of knowledge concerning the neural substrates of anxiety and social memory," James Leckman, M.D., a Yale University psychiatrist and vasopressin-social behavior authority, told *Psychiatric News*. "In their study of mice that were genetically modified to lack the vasopressin V1a receptor, they have convincingly demonstrated that this receptor is crucial in male mice for the development of social recognition and the regulation of anxiety-like behaviors.

"While I agree with the authors that the V1a receptor may be an appropriate pharmacological target for social and anxiety disorders, further study is needed to document the impact of this deletion in female mice."

Leckman also noted that scientists need to "develop a more complete and convincing model of how the V1a-knockout animals. . . resemble children with pervasive developmental disorders, such as autism, who show little interest in other people."

The study was funded by the National Institutes of Health and a Yerkes Center grant.

An abstract of the study, "Profound Impairment in Social Recognition and Reduction in Anxiety-Like Behavior in Vasopressin V1a Receptor Knockout Mice," is posted online at <www.nature.com/cgi-taf/DynaPage.taf?file=/npp/journal/v29/n3/abs/1300360a.html>. ■

Can Schizophrenia Benefit From Anemia Treatment?

Researchers are investigating whether the hormone erythropoietin will improve cognition in people with schizophrenia.

BY JOAN AREHART-TREICHEL

One never knows where valuable new treatments for schizophrenia might come from. Take, for instance, erythropoietin, a hormone secreted by the kidneys that increases the rate of production of red blood cells.

Hannelore Ehrenreich, M.D., a psychiatrist with the Max-Planck Institute for Experimental Medicine in Goettingen, Germany, and colleagues believe that it might constitute a safe and effective new treatment for the negative symptoms of schizophrenia, which are not countered well by the antipsychotic medications on the market.

In essence, they reported in the January *Molecular Psychiatry*, erythropoietin has been used for a number of years to treat anemia in people with chronic kidney failure and has been found to be safe. What's more, cognitive improvement has been noted in kidney-failure patients after they receive erythropoietin. And now this research group has found that when erythropoietin is injected into the bloodstream of either humans or test animals, it is able to get into their brains; that receptors for erythropoietin are densely expressed in the cortex and hippocampus of schizophrenia subjects; and that peripherally injected erythropoietin enhances cognitive function in mice in conjunction with an aversion task involving cortical pathways presumably impacted by schizophrenia.

Ehrenreich told *Psychiatric News* that she and her team have launched a multicenter study to test, for example, whether erythropoietin could be given to schizophrenia patients in conjunction with their usual antipsychotics.

An abstract of "Erythropoietin: A Candidate Compound for Neuroprotection in Schizophrenia," is posted online at <www.nature.com/cgi-taf/DynaPage.taf?file=/mp/journal/v9/n1/abs/4001442a.html>. ■

ICA NOTES
1/4

OSLER (TUT)
1/4

GLAXO SYMPOS (FAVA)
1/2H 4C

Pediatricians Logical Choice To Identify Depressed Moms

For this idea to work, however, mothers must be able to develop a trusting relationship with the pediatrician and be assured that intervention won't lead to the loss of their child.

BY MARK MORAN

Mothers of infants and small children welcome the opportunity to discuss their own mental health with the child's pediatrician, including the possible need for referral to a specialist. Such a conversation, however, can happen only in the context of a trusting relationship.

Many mothers are fearful of being judged a bad parent if they acknowledge depression or other mental health problems, according to qualitative research published in the March *Pediatrics*.

"Despite the fact that mothers want to turn to their pediatricians to talk about stress and depression, they fear being judged," said study co-author Amy Heneghan, M.D., an assistant professor of pediatrics at Case Western Reserve University School of Medicine in Cleveland. "Our research shows how very important it is for the pediatrician and the mother to develop a trusting relationship so that she will have an opportunity to talk about things that cause family stress."

Forty-four women in seven focus groups of two to 12 members answered questions about parenting stresses, mental health and illness, and ways in which pediatricians might help them address concerns about their own mental health. For many mothers of young children, the pediatrician is the only health professional they see with any regularity, Heneghan said.

Heneghan said the sample was "purposive"—meaning that women responded on their own to an advertised request for mothers to participate in focus groups, and many may have responded because of stresses they were experiencing as parents. The average score on the 29-item Psychiatric Symptom Index for the participating women was 26.3 (scores over 20 reflect risk for depression).

Heneghan told *Psychiatric News* that women were generally receptive to being referred to a specialist, including a psychiatrist. But she said the women again expressed the need for such a referral to arise out of a trusted relationship.

A striking finding was the antipathy toward involving social workers, because of their association with child protection agencies—a sentiment that was common across all socioeconomic groups but was especially strong among poorer women.

"Mothers in lower-socioeconomic-status groups were particularly fearful of social work intervention, because they believed that primary function of medical social workers is to remove the child from the home rather than to act as a resource for help," according to the *Pediatrics* report.

These were among other themes that emerged from the study:

- Mothers believed in the importance of accepting responsibility for monitoring their own well-being and that of their child.
- Mothers expressed the need to share parenting experiences, stressors, and depressive symptoms with someone (most preferred to speak with family or friends rather than with their child's pediatrician).
- Open communication with a pediatrician who listens well was perceived by mothers in all groups as very important.
- Mothers expressed interest in receiving supportive written communication about parenting stress and depressive symptoms from pediatricians.

Psychiatrist Nada Stotland, M.D., said the attention of pediatricians to the mental health of mothers is key to finding cases of depression.

"They are at the pediatrician's office anyway, talking about things they care about—whether the baby is sleeping, eating, and growing," she said. "If they are relatively healthy, they are going to be there much more regularly than they are at any other health care provider's office. And when a mother's depression begins to affect her functioning, she will still get that baby to the pediatrician. Certainly, it would be great if women were seeking out a psychiatrist first, but you're talking about scheduling another appointment. Here you have a population of women at risk already in a doctor's office."

At the same time, she wondered how many mothers actually have one consistent pediatrician that they see over a long-enough period to develop the kind of trusting relationship that mothers seek.

"Most people are in HMOs and large clinics, with all sorts of people handling their medical records," she said. "How would someone develop a trusting relationship?"

For the same reason, she said the concerns expressed by mothers about being judged a bad parent are far from surprising, and especially poignant in light of recent controversies surrounding privacy of medical records *(Psychiatric News*, April 2).

"We have mandatory reporting laws, and even as we have some kids suffering horrible neglect without the system taking care of them, we also have a system that has taken kids away without good reason," Stotland said. "The likelihood is small, but the way the human mind works, if the threat is

please see ***Depressed Moms*** *on page 69*

PRMS

1/2H

WYETH SYMPOS

(KALIN)

1/2H

COMPILED BY JIM ROSACK

Regulatory and Legal Briefs

• ***Paroxetine–controlled release*** was approved by the FDA for intermittent dosing for the treatment of premenstrual dysphoric disorder (PMDD). Efficacy was established in a placebo-controlled study of 366 patients in whom both 12.5 mg and 25 mg dosing for the two weeks prior to onset of menses were significantly more effective than placebo in reducing the emotional and physical symptoms of PMDD.

• ***Eszopiclone*** won an approvable letter from the FDA for treatment of insomnia. The preliminary approval was the result of a New Drug Application made up of 24 clinical studies, including more than 2,700 adult and elderly patients, and nearly 60 preclinical studies. The new hypnotic appears to be effective at inducing and maintaining sleep through the night and into the early morning without significant hangover effects the next day. Sepracor, which will market the new medication under the brand name Estorra, hopes for final FDA approval later this year.

• Pfizer has submitted ***ziprasidone*** to the FDA for relabeling. The Supplemental New Drug Application requests three changes in the product labeling: the lack of adverse effects on blood glucose and lipid metabolism, removal or modification of the strongly worded warning regarding potential heart-rhythm disturbances (none has been documented since the product entered the market in February 2001), and an increase in the therapeutic dosing range. Pfizer hopes for FDA approval by late 2004.

Research Briefs

• ***Theophylline*** may be an effective alternative for the approximately 30 percent of children and adolescents who have ADHD and do not respond adequately to traditional stimulant therapy or cannot tolerate its side effects. A xanthine psychomotor stimulant most commonly used as a bronchodilator for the treatment of asthma, theophylline was compared with methylphenidate in 32 children with ADHD over six weeks. No significant differences were seen between the two groups on the Teacher and Parent Rating Scale. Roughly equal improvement was seen overall as assessed by child psychiatrists. The most frequent adverse effects for methylphenidate were headache and insomnia, while stomach upset was the most frequent complaint of those taking theophylline.
J Clin Pharm Ther 2004; 29:139-144

• ***Galantamine*** is associated with sustained cognitive benefits for at least 36 months in patients with Alzheimer's disease. In two double-blind, placebo-controlled clinical trials spanning three years, patients taking galantamine declined roughly half as much as did those taking placebo, as measured by the Alzheimer's Disease Assessment Scale 11-item cognitive subscale, or ADAS-Cog. Patients who discontinued galantamine prior to the three-year point declined at a similar rate before stopping the medication, then declined at the same rate as those taking placebo within a short time of discontinuing galantamine. The most common adverse effects associated with galantamine were stomach upset and insomnia.
Arch Neurol 2004; 61:252-256

• ***Lamotrigine*** effectively improved depressive symptoms without inducing a switch to mania or hypomania in a one-year, open-label extension study. Of 135 patients completing an acute-treatment trial, 124 entered the extension, including 47 who had received placebo during the acute phase. In the 69 patients (56 percent) who completed the extension phase, significant and sustained improvement was seen on scores on the Montgomery-Asberg Depression Rating Scale. By week 4 of the extension phase, 81.4 percent had achieved remission, and mania/hypomania occurred less frequently than in the 12 months prior to the study's start. Headache was the most frequently cited adverse event.
J Clin Psychiatry 2004; 65:204-210

• ***Nefazodone*** appears to be both effective and tolerable regardless of whether a patient has tried and failed another SSRI prior to taking nefazodone. Anecdotal evidence had suggested that recently discontinuing another SSRI increased the risk of a patient's not responding to or tolerating nefazodone. In a comparison of adults with depression, a group of 13 patients who had not taken any antidepressant in the previous six months was com-

Medication Names and Manufacturers

The following medications appear in this edition of Med Check:

• **Eszopiclone:** Estorra (Sepracor; pending final FDA approval)
• **Galantamine:** Reminyl (Janssen)
• **Lamotrigine:** Lamictal (GSK)
• **Methylphenidate:** Ritalin (Novartis), generics
• **Modafinil:** Provigil (Cephalon)
• **Nefazodone:** Serzone (BMS)
• **Paroxetine–controlled release:** Paxil CR (GSK)
• **Paroxetine mesylate:** Pexeva (Synthon)
• **Theophylline:** generics
• **Ziprasidone:** Geodon (Pfizer)

pared with a group of 13 who had discontinued an SSRI within one to four weeks of starting nefazodone, either for intolerable side effects or for lack of efficacy. All patients received open-label nefazodone, 50 mg p.o. b.i.d., and doses were titrated as tolerated to a maximum of 600 mg a day. Patients were followed for 12 weeks. Depression scores in both groups improved significantly; however, no significant difference was seen between the groups. In addition, there was no significant correlation between prior SSRI use and discontinuation of nefazodone for lack of efficacy or for intolerable side effects.
Depress Anxiety 2004; 19:43-50

• In Denmark, whether patients are prescribed newer ***SSRIs*** or older, less-expensive ***tricyclic antidepressants*** does not appear to be based on socioeconomic status. A longitudinal study of more than 305,000 adults without antidepressant prescriptions at the start of the study were followed over five years. The one-year incidence rate of depression was 1.7 percent and increased with age. Depression was more common in those who were female, single, unemployed, and less educated and had lower income. Over the five-year study, a total of 82 percent of those who developed depression were prescribed newer-generation antidepressants, and prescribing did not correlate with socioeconomic status, education, or annual income. However, those who were younger and who were single were more likely to be prescribed an SSRI.
Eur J Clin Pharmacol 2004; 60:51-55

• ***Ziprasidone*** may effectively increase response to SSRIs in those with SSRI-resistant depression. Ziprasidone, a second-generation antipsychotic with strong effects at the 5-HT1A receptor, is thought to have mood-elevating properties itself. Of 20 patients who had failed to respond to an adequate trial of an SSRI, 13 patients completed a six-week, open-label augmentation study using ziprasidone. Eight of those 13 (61.5 percent) met criteria for response (50 percent or greater reduction in symptoms), and five of the 13 (39 percent) met remission criteria. Ziprasidone was safe, with no cardiac effects and little or no weight gain. The most common adverse effects noted with ziprasidone in addition to an SSRI included fatigue/sedation, sleep disturbance, dry mouth/stomach upset, and restlessness/tremor.
J Clin Psychiatry 2004; 65:217-221

• ***Modafinil*** may be an effective adjunct treatment for improving global functioning and clinical condition, as well as reducing fatigue in patients with schizophrenia or schizoaffective disorder. In a four-week, open-label pilot study, 11 patients received 100 mg to 200 mg of modafinil a day in addition to their antipsychotic therapy. In assessments by a blinded clinician and the study investigator, patients' global functioning was rated as significantly improved. Eighty-nine percent of patients rated themselves as clinically improved. Fatigue was significantly improved and tended to influence cognitive function positively. Positive symptoms were well controlled. Adverse events associated with the addition of modafinil included dry mouth and headache, and two patients developed hallucinations. One patient discontinued the study due to inadequate antipsychotic response.
Clin Neuropharmacol 2004; 27:38-43

Industry Briefs

• IMS Health, a Connecticut-based, global research firm that tracks world pharmaceutical markets, reported that a 9 percent growth rate in 2003 pushed total global pharmaceutical sales to $492 billion. North America, the European Union, and Japan accounted for 88 percent of those sales, while the North American market accounted for the largest increase in sales (an 11 percent increase to $229.5 billion). Antidepressants were the third-largest component of sales, increasing 10 percent worldwide to $19.5 billion. Antipsychotics came in at number five, increasing a whopping 20 percent for the year, for a total of $12.2 billion in worldwide sales. Two psychotropic medications made the top 10 leading products in global sales for 2003: Eli Lilly's Zyprexa was third with $4.8 billion in sales (up 13 percent from 2002) and Pfizer's Zoloft was 10th with $3.4 billion in global sales (up 11 percent over 2002). ■

Depressed Moms

continued from page 66

awful enough—and there is nothing more horrible to a parent than losing their child—that fear is going to loom very large."

Heneghan said her research indicates the need for treatment approaches that view the depressed woman in the context of motherhood and family.

"Mothers with depression think of themselves as mothers first, women second, and depressed third," Heneghan told *Psychiatric News*. "We need to think much more expansively about treatments for subclinical and clinical depression that incorporates peer and family support, child and mother support programs, and pharmacologic and cognitive and interpersonal therapies."

The study was funded by the Robert Wood Johnson Foundation and the Children's Research Foundation of Rainbow Babies and Children Hospital, Cleveland.

An abstract of the study, "Will Mothers Discuss Parenting Stress and Depressive Symptoms With Their Child's Pediatrician?," is posted online at <http://pediatrics.aappublications.org/cgi/content/abstract/113/3/460?>. ■

Buprenorphine Depot Formulation Relieves Withdrawal Symptoms

Buprenorphine appears to work better than substance abuse experts had anticipated, with expanding dosage forms and indications.

BY JIM ROSACK

A depot-injectable formulation of the partial μ-opioid agonist, buprenorphine, appears to extend opioid blockade significantly and minimizes the risk of the medication itself being abused by patients who are addicted to opiates. In addition, the medication may be just as effective in patients who are addicted to both opiates and cocaine.

The novel depot formulation of buprenorphine, developed by Biotek Inc. in collaboration with the National Institute on Drug Abuse (NIDA), is investigational, with Phase II clinical studies having been recently completed. The proposed brand name is Norvex.

The active medication is suspended in polymer microcapsules that release buprenorphine for approximately 40 days after subcutaneous injection. Studies in animals have indicated the formulation suppresses opioid withdrawal for as long as 60 days in morphine-dependent animals.

A report by George Bigelow, Ph.D., a professor of psychiatry and behavioral sciences at Johns Hopkins University School of Medicine, and his colleagues detailed results of the first open-label clinical trial of the new formulation in humans. That report appeared in the January *Drug and Alcohol Dependence*.

Five opioid-dependent volunteers received a single subcutaneous injection containing 58 mg of buprenorphine, and they were assessed during at least four weeks of residential treatment followed by two weeks of outpatient observation. The depot formulation appeared to provide effective relief from symptoms of opioid withdrawal, with none of the five participants requiring additional medication for withdrawal relief after receiving their depot injection.

In addition, the depot formulation appeared to be well tolerated, with no significant side effects, signs of intoxication, or respiratory suppression. Two of the five patients developed transient pain and/or tenderness at the site of injection, which resolved within seven days.

Subjectively, all five patients reported relief and felt "normal" and "comfortable" through the end of the study at six weeks. Observer assessments were similar. Illicit drug use was checked through both urine and blood analyses.

All five patients achieved opioid detoxification by week 4 and were discharged to the outpatient phase of the study, having required no additional medications for withdrawal and having no significant observable symptoms of withdrawal. Urine samples were negative, with one exception: one patient's urine screen was positive in week 6, due to prescription pain medication used for significant dental problems.

A second recently published report indicates that buprenorphine may be effective at reducing cocaine and heroin use in patients addicted to both.

The report, conducted by Ivan Montoya, M.D., M.P.H., a research scientist in NIDA's Division of Treatment Research and Development in Baltimore, appeared in the January *Clinical Pharmacology and Therapeutics*.

Two hundred outpatients dependent on both drugs were randomly assigned to receive buprenorphine (2 mg, 8mg, or 16 mg a day or 16 mg every other day) or placebo for 13 weeks. All patients also received weekly individual drug-abuse counseling for that same period.

The researchers sought to answer two questions: How many subjects taking buprenorphine stopped using heroin and

please see ***Buprenorphine*** *on facing page*

Buprenorphine Course in New York

Psychiatrists who want to be certified for prescribing office-based buprenorphine therapy for opiate addiction may want to register on site for a CME course being offered at APA's 2004 annual meeting next month in New York City.

The course, "Office-Based Buprenorphine Treatment of Opioid-Dependent Patients," will be offered on Wednesday, May 5, in Gramercy A on the second floor of the Hilton New York. The course runs from 8 a.m. to 5 p.m.

Physicians seeking certification must complete an eight-hour course conducted by one of four education providers jointly recognized by the Substance Abuse and Mental Health Services Administration and the Drug Enforcement Administration. APA is one of those providers.

Serving as course co-directors are Thomas Kosten, M.D., and Eric Strain, M.D. Faculty include Laura McNicholas, M.D., and Walter Ling, M.D.

More information about the course and course registration is available by e-mailing Elizabeth Rumsey at APA at erumsey@psych.org.

LILLY SYMPOS (GOLDBERG)
ISL 4C

Family Factors Less Crucial In Episodic Depression

While chronic depression can sometimes be milder than acute depression, chronic depression appears to be much more severe when viewed over time and from the perspective of familial liability.

BY MARK MORAN

Chronic depression appears to be distinguished from episodic depression by a confluence of genetic and nongenetic influences transmitted within the family of the patient, which may contribute to the more pernicious course of chronic depression.

Rates of major depressive disorder are significantly greater among relatives of adolescents with dysthymic disorder and chronic major depressive disorder than among the relatives of adolescents with episodic major depressive disorder, according to a report in the April *American Journal of Psychiatry.*

In turn, the rates of major depressive disorder were greater among relatives of adolescents with episodic major depressive disorder than among the relatives of adolescents with no history of mood disorder.

"Chronic depression is an understudied topic, and it is often underrecognized in clinical practice," said lead author Daniel Klein, Ph.D. "Clinicians often focus on the acute episode and don't do a careful assessment of prior course. I believe that this study adds to a growing literature suggesting that chronicity is an important dimension to consider in assessing depression."

Klein is with the department of psychology at the State University of New York at Stony Brook.

In the study, 2,615 first-degree relatives of 30 adolescents with dysthymic disorder, 65 adolescents with chronic major depressive disorder, 3,123 adolescents with episodic major depressive disorder, and 392 adolescents with no history of mood disorder were assessed by direct interview and informant records. The analysis used data from the family study component of the Oregon Adolescent Depression Project, a longitudinal investigation of a large sample of community-dwelling adolescents, to examine the distinctions between dysthymic disorder, chronic major depressive disorder, and episodic major depressive disorder.

Klein told *Psychiatric News* that the findings are consistent with previous research suggesting that chronic and episodic depressions may differ etiologically, as well as in terms of their prognosis and course.

"For this reason, clinicians should be sure to carefully assess prior course in depressed adolescents and adults," he advised.

In addition, chronic depressions, particularly dysthymic disorder, are often viewed as mild conditions, he said. "This study also adds to the literature challenging that perspective," Klein continued. "While some chronic depressions may be milder than acute depressions at a given point in time, when viewed over the course of time and from the perspective of familial liability, they appear to be much more severe conditions."

The study was supported by grants from the National Institute of Mental Health.

The study, "Family Study of Chronic Depression in a Community Sample of Young Adults," is posted online at <ajp.psychiatryonline.org/cgi/content/full/161/4/646>. ■

Buprenorphine

continued from facing page

cocaine? And of those subjects who didn't stop using, did any decrease their usage?

The researchers found that the highest dose of buprenorphine (16 mg daily) was the most effective at stopping both heroin and cocaine use, as well as decreasing use in those who continued to test positive. In the group receiving 16 mg a day, the number testing positive for heroin fell by 43 percent, and the number testing positive for cocaine fell by nearly 53 percent. Urine concentrations in those continuing to test positive for heroin use fell by 92 percent, and in those continuing to test positive for cocaine use, by 95 percent. The group taking 8 mg a day of buprenorphine also had statistically significant reductions in both the number of subjects continuing to use both heroin and cocaine and the amount of drug used. However, the effect was much smaller.

No statistically significant effects were seen at 2 mg. In addition, those taking 16 mg every other day improved slightly, but generally less than those receiving 8 mg every day.

Together, these two studies support the growing evidence base for the effectiveness of buprenorphine in the treatment of addiction, specifically to opiates and possibly to cocaine. Montoya and his colleagues noted that in their analysis the therapeutic effect of the drug on cocaine use appears to be independent of that on opiate use.

Abstracts of "Open-Label Trial of an Injection Depot Formulation of Buprenorphine in Opioid Detoxification" and "Randomized Trial of Buprenorphine for Treatment of Concurrent Opiate and Cocaine Dependence" are posted online at <www.sciencedirect.com>. ■

HJANSSEN JU-
BILOSO/LAMENTOSO
1/4

HS--ISS
CALL FOR SUBMISSIONS
1/4

WYETH SYMPOS (LIEBOWITZ)
1/2H BW

Imaging Data Uncover Mysteries of Love

Romantic love is a rare commodity in the realm of psychiatric research. At a session at next month's APA annual meeting, a well-known anthropologist will use MRI data to expose some of the mysteries of love.

BY PHILIP MUSKIN, M.D.

People live for love, die for love, and kill for love. In a recent study of 114 men and women who had recently been rejected in love, 40 percent were clinically depressed, and an estimated 50 percent to 70 percent of American women who are victims of murder die at the hands of a spouse or lover.

At APA's 2004 annual meeting, anthropologist Helen Fisher, Ph.D., will present new functional magnetic resonance imaging (fMRI) data on the brain in love and show how this brain system affects worldwide patterns of marriage and divorce and crimes of passion. Her presentation will take place on Wednesday, May 5, at 2 p.m. in room 1E07 of the Javits Center.

Fisher is a research professor at Rutgers University and author of four books on the evolution of human sexuality, romantic love, attachment, and gender differences in the brain and behavior. She is the author of the new book *Why We Love: The Nature and Evolution of Romantic Love* (Holt).

Fisher proposes that romantic love is a developed form of mammalian mating drive (not an emotion) designed to motivate men and women to focus their courtship energy on preferred reproductive partners, thereby conserving mating time and energy.

She and colleagues at the Albert Einstein College of Medicine and SUNY Stony Brook put 17 people who had "just fallen madly in love" into an fMRI scanner to identify the brain circuitry of this universal phenomenon. Participants alternately viewed a photo of a beloved and a photo of a familiar, emotionally neutral individual, interspersed with a distraction task. Dopamine pathways associated with reward and motivation were activated, regions of activation changed as the relationship endured, and men and women showed some different brain responses.

Fisher maintains that romantic love is largely distinct from the sex drive; that it evolved to facilitate mate choice; that gender differences in romantic passion reflect varied ancestral male and female reproductive strategies; that changes in romantic attraction across time are adaptations for childrearing; that this brain system is closely integrated with brain networks for hate/rage; that "frustration attraction," "abandonment rage," and "rejection depression" are Darwinian adaptive mechanisms; and that romantic love can become a life-threatening addiction. ■

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

Official Sessions: Be There!

If you are a voting member of APA, you are encouraged to attend APA's annual Business Meeting and Annual Forum while attending the 2004 annual meeting in New York City next month. The session will be held Sunday, May 2, at 12:30 p.m. in the Westside Ballroom on the fifth floor of the Marriott Marquis. APA's officers will make their annual reports to the membership and respond to questions from the floor.

Later that afternoon is the official Opening Session of the annual meeting. Outgoing President Marcia Goin, M.D., will present her presidential address, and Incoming President Michelle Riba, M.D., will respond. Attending this session is an excellent way to feel connected to the profession and learn about the major issues that APA has been addressing this past year and will continue to work on in the coming year. The Opening Session will be held from 5 p.m. to 6:30 p.m. in Hall 3E on Level 3 of the Javits Center.

The final official session at the annual meeting—the Convocation of Distinguished Fellows—will be held Monday, May 3, at 5:30 p.m. in Hall 3E on Level 3 of the Javits Center. In addition to inducting APA's new distinguished fellows, Goin will present presidential commendations to six individuals who have dedicated their psychiatric careers to improving the lives of people with mental illness in numerous ways. The William C. Menninger Memorial Convocation Lecture will be presented this year by social observer and best-selling author Tom Wolfe.

How to Register

Although the advance registration deadline for APA's 2004 annual meeting in New York City is now past, APA members can still attend the annual meeting by registering on site at the Javits Center in the North Pavilion. Registration is open each day of the meeting, May 1 through May 6.

Additional information about the meeting is posted on APA's Web site at www.psych.org under "2004 APA Annual Meeting." Hotel reservations may be made at the same site by clicking on "APA Members Reserve Your Hotel Online."

Build a Memorable Dinner One Course at a Time

In New York, the food problem will be so many choices and so little time. In the last of our articles on the city's culinary bounty, we provide the elements for you to compose one fabulous dining fantasy.

BY DAVID M. MCDOWELL, M.D.
CRAIG WILLIS

This is the last article in our "Dining in New York" series, and we hope you've enjoyed it. The first article focused mainly on fine dining, and the second was more of a journey through the boroughs. This article focuses on one meal from start to finish, and we will do that in just a moment.

But first, we must confess a desire to keep you all in New York City as our prisoners for at least a month. There are just too many places we haven't mentioned—and that should be mentioned—places to eat at, cuisines to try, regions to explore. The melting pot of New York is no mere cliché. From Le Cirque to the street-cart falafel; from homey comforts like macaroni and cheese to exotic, sometimes bizarre, dishes such as fugu and marigolds on a bed of lightly dressed rye grass. O.K., we made that last one up, but you get the drift. Unfortunately, the annual meeting allows only a limited amount of time for experiencing the tastes of New York, and we hope we have given you at least a hint of what is here.

Let's start our meal tonight with an aperitif at Teany on the Lower East Side, where you'll find a great selection of teas and a vegan nosh or three. The space is co-owned by Moby, the venerable voice of vegan club music and other PETA-related dishes. Don't hit us with your swizzle stick just yet. It's not the prettiest place in town, nor is the service anything to rave about, but it is a very New York Lower East Side experience. And the tea and nosh are really good.

Now let's have a cocktail before dinner this evening; we'll grab a cab and head to Greenwich Village and seat ourselves in Gotham Bar & Grill's vast space. The bartender here knows what he's doing, so have no fear about ordering that obscure cocktail you've heard tell about. Or let him pour you a great martini and then sit back and relax, enjoy the space, and strike up a conversation with someone at the bar. Or eavesdrop on one.

Getting a little hungry now? Let's take a walk around the corner to Otto for an appetizer. Chef Mario Batalis's newish space is a take on a pizzeria. But this isn't pizza as most of you know it—it's the real thing. Several of the ingredients are made in house, such as the salami and mozzarella. One of the most famous pizzas here is the Lardo. Yes, lardo. It's the house-cured pork fatback, and it's not to be missed. Sublime would only begin to describe it. But let's begin with a few plates of olives, some fungi mista, some brussel sprouts and Vin Cotto, and maybe some preserved swordfish with ramps. If anyone else joins us, well, take some mussels with pepperonata and mint as well. Perfect, isn't it?

Now take a look at the wine list. Have you ever seen an Italian wine list that long before? Well, come back another time for a bottle and the Otto Lardo (you know you want to), but right now let's head over to Blue Water Grill for dinner. The space was once a basement speakeasy, but it has been transformed into a beautiful setting with brick and wood. Minimalist, but not cold. And the food? This should be the standard for seafood. And take a look at that raw bar! Superior in every way. Go ahead order anything. It will be divine.

Why don't we walk a bit, get some fresh air to aid our digestion, and enjoy the sights and sounds of Union Square while we head over to Sage in the Gramercy Park area where we'll have an after-dinner drink before saying good night. I think the bar upstairs here is awfully nice and will be perfect for having a snifter of cognac or your preferred digestive. Let's sit here for a moment and relax.

We've enjoyed being your host, and we hope you'll be able to come back soon. This evening was wonderful, wasn't it? Now that's eating in New York! ■

Heavenly Hash

- **Blue Water Grill:** 31 Union Square, (212) 675-9500
- **Gotham Bar & Grill:** 12 East 12th Street, (212) 620-4020
- **Otto:** 1 Fifth Avenue, (212) 995-9559
- **Teany:** 90 Rivington Street, (212) 475-9190
- **Sage:** 331 Park Avenue, (212) 253-8400

FOREST NAMENDA

P4C

FOREST NAMENDA

P4C

FOREST NAMENDA

P4C

FOREST NAMENDA

P4C

FOREST NAMENDA

P4C

FOREST NAMENDA

P4C

FOREST NAMENDA

P4C

FOREST NAMENDA

P4C

Helping Athletes Cope When Their Star Stops Shining

Whether you are an active sports participant or simply an "armchair quarterback," you should find an annual meeting symposium on sport psychiatry to be both interesting and useful.

BY JOAN AREHART-TREICHEL

What is it like being not just a psychiatrist, but also the parent of a star athlete who loses star status?

What happens to professional boxers when their careers are on the decline?

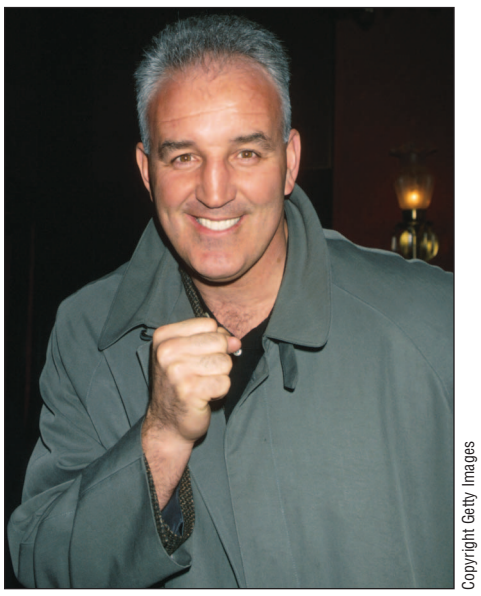
These two questions about losing the spotlight in the sports world will be addressed at a symposium at APA's 2004 annual meeting in New York City next month. The symposium, titled "Contemporary Issues in Sport Psychiatry," will take place on Tuesday, May 4, from 2 p.m. to 5 p.m. in the Javits Center, room 1E14, Level 1.

The symposium will be chaired by Ronald Kamm, M.D., president of the International Society for Sport Psychiatry, headquartered in New York City.

When he was in high school, Alec Baker was a goalie for an elite junior hockey team —a "star." Then he experienced an injury and lost his star standing. What this experience did to his identity and to that of his parents will be discussed at the symposium not just by Alec, but by his parents, Howard Baker, M.D., a psychiatrist, and Maggie Baker, Ph.D., a psychologist. Tom Newark, M.D., a sport psychiatrist who works with adolescents, will also comment on the subject.

Gerry Cooney, a former professional boxer, will talk about what it was like for him to leave the world of professional boxing and make the transition into the "real" world. He will also talk about an organization he founded in 1998, called FIST (Fighters' Initiative for Support and Training), which tries to help professional boxers make such transitions. Kamm, who is also involved with FIST, will discuss it as well.

"Career termination is really traumatic for most athletes, but even more so for boxers," Kamm explained in an interview with *Psychiatric News*. "They live in a very insular world. Often they are encouraged to drop out of high school by their managers and promoters, and they do nothing but train in the gym and relate to other boxers. Toward the end of their career, they don't have any other skills, so they stay in boxing too long, and they become opponents or sparring partners, and that is really when the brain damage occurs. So what we're doing with FIST is giving them an alternative. When their skills are starting to erode, we're helping them with vocational placement, career-termination counseling, and medical evaluations."



Copyright Getty Images

Gerry Cooney, who stepped into the ring with the likes of Ron Lyle, Jimmy Young, Ken Norton, Michael Spinks, and George Foreman, founded FIST (Fighters' Initiative for Support and Training) in 1998.

Other persons on the FIST team, notably its president, Joe Sano, will add their observations.

Stacy Robinson, formerly a wide receiver for the New York Giants and currently director of player development for the National Football League (NFL), will be talking about approaches the NFL uses to try to keep athletes out of trouble. Eric Norse, M.D., a sport psychiatrist who works with teams in the Baltimore area on issues such as violence and drug abuse, will put Robinson's comments into a sport psychiatry perspective.

There are various reasons why psychiatrists who are not directly involved in sports should attend this symposium, Kamm continued—for example, professional athletes such as Kobe Bryant are getting into legal trouble, the issue of career termination occurs in all sports, and many psychiatric patients engage in sports.

Kamm, in fact, would like to see more psychiatrists become engaged in sports medicine *(Psychiatric News*, April 4, 2003). "Psychiatrists bring something to the table that sport psychologists don't have," he explained. "Being more adept with the biopsychosocial model, we can diagnose underlying disorders and treat them with psychotherapy and medication, as well as using the cognitive-behavioral techniques of the sports psychologists. We are the specialists who most naturally interface with other medical personnel in the care of athletes—pediatricians, orthopedic surgeons, physical therapists, and sports medicine specialists."

More information about Kamm, sport psychiatry, and the International Society for Sport Psychiatry is posted online at <www.mindbodyandsports.com>. ■

AMERICAN PSYCHIATRIC FOUNDATION

1/2H

WYETH SYMPOS (EVANS)

1/2H

For One Car-Free Day, Peddlers Will Rule

APA annual meeting attendees will be greeted by a sea of bicyclists on May 2 when the city hosts its annual five-borough bike tour.

BY KATE MULLIGAN

Try to imagine a New York City without automobiles. That seemingly impossible vision becomes reality for one day every spring when streets in all five boroughs are turned over to bicyclists.

This year, on Sunday, May 2, an estimated 30,000 cyclists will ride on 42 miles of traffic-free streets, in the largest bicycle tour in the United States.

Bike New York begins at 7 a.m. in Battery Park in Manhattan and travels through the Bronx, Queens, and Brooklyn and into Staten Island over the Verrazano-Narrows Bridge.

The event closes with a festival at Fort Wadsworth in Gateway National Recreation Area on Staten Island.

Bike New York got its start in 1977 when a local schoolteacher asked the city's hostelling organization HI-AYH to help create a bicycle education and safety program for the New York City Board of Education. The result was bicycle clinics followed by a tour around the five boroughs to practice bicycle safety.

Judging by the comments on the "Reviews and Raves" section of the event's Web site at <www.bikenewyork.org>, Bike New York might be in danger of becoming a victim of its own success.

One anonymous writer warns, "If there were 30,000 riders, there were at least 20,000 cell phones." But, another participant wrote, "The ride itself is so well run from the water stops to traffic control and much, much more!"

Most participants come from the Northeastern part of the United States, but Japan sends a large contingent because of the country's television publicity of the event.

More information on Bike New York is posted online at <www.bikenewyork.org>. ■

Courtesy of Bike New York

Curriculum

continued from page 36

conducted among a small sample of black psychiatrists at the 2003 meeting of the Black Psychiatrists of America.

Respondents, when asked about why they thought people may be resistant to implementing such a curriculum, replied that many psychiatry supervisors lack an awareness of cultural issues and also that there may be a lack of motivation because "teaching cultural sensitivity is not linked to licensure or accreditation," Chambers said.

In addition, survey respondents speculated that supervisors may be afraid to offend residents in discussions of issues having to do with race and ethnicity. "Political correctness has taken the dialogue away," Chambers observed.

Kathy Sanders, M.D., residency training director at the MGH/McLean adult psychiatry program, is working with Benson, Wills, and Chambers to incorporate training on African-American mental health issues into a broader sociocultural curriculum.

Many of their recommendations will be presented in a daylong seminar on May 7 in Boston.

The seminar will cover subjects such as ethnopsychopharmacology, African-American family structure, historical perspectives on African-American culture, and topics such as substance abuse and forensic psychiatry in the context of African-American culture. ■

Storied Neighborhood Emblematic Of Immigrant Experience

For all its troubles, Five Points was where America's newest citizens survived and built better lives for children, most of whom would move up and out of the neighborhood, according to historian Tyler Anbinder.

BY MARK MORAN

Five Points, 1827, Museum of the City of New York

Walk around New York City neighborhoods long enough, and you are liable to wander, unaware, through some sites of notable social or cultural history that time has transformed, obscuring a vivid and rambunctious past.

One of those places is in what is now Chinatown, at the intersection of Orange, Cross, and Anthony streets in lower Manhattan—a crossing whose five corners gave the name to the 19th century neighborhood known as Five Points. The notorious character of the neighborhood and importance as a landmark in the American immigrant experience are captured in Tyler Anbinder's 2001 book, *Five Points: The 19th Century New York City Neighborhood That Invented Tap Dance, Stole Elections, and Became the World's Most Notorious Slum.*

The account, a *New York Times* Notable Book, is published by Penguin Putnam Inc.

The Five Points neighborhood was a hotbed of vice, decrepit living conditions, and shenanigans of all kinds—so much so that touring the neighborhood became a kind of international attraction for those wanting to see the underside of the American Dream. But as Anbinder recounts, the story of Five Points is greater than the sum of its pathologies.

"Five Pointers' stories are as old as America itself, and yet as contemporary as the current waves of immigrants that continue to reshape our society," he writes.

Anbinder recounts the history of Five Points from its origins in the late 1700s as a site of slaughterhouses, meat-packing factories, and tanneries—industries whose noxious fumes and reliance on cheap, unskilled labor set the stage for an inexorable decline. As immigration swelled the city in the 1820s and 1830s, the small buildings that had dotted the neighborhood gave way to apartments and tenements, rented to African Americans and waves of poor immigrants—from Ireland, especially, but also from Italy, Germany, and Eastern Europe.

By the 1830s, the neighborhood's "disreputable fate" was sealed when it became a center of prostitution. By this time, the press had begun to refer to the neighborhood as Five Points and to chronicle its crime and squalor. In 1834, what Anbinder calls "a full-scale racial pogrom" broke out when antiabolitionists rampaged through the neighborhood attacking African-American homes, businesses, and churches.

Later that year and the next, riots rocked the neighborhood again. "They revealed racial, ethnic, and religious fault lines that New Yorkers had previously recognized but preferred to ignore," Anbinder writes. "Over the next 65 years, Five Pointers would often find themselves at the epicenter of the struggles—ones that would help shape modern New York."

For all its troubles, Five Points was also a place where America's newest citizens built the foundations of better lives for children who would escape the neighborhood. Anbinder documents the lives of some of these strivers.

For many immigrants the conditions in Five Points were actually an improvement over what they had left. Anbinder pays particular attention to Irish immigrants who had left the Lansdowne estate, a farm in Ireland that was blighted by the potato famine in the 1840s. The appalling conditions on the plantation, the dire physical condition to which the farmers were reduced, and the difficulty of their journey across the ocean are richly documented.

So Five Points became a home. "By the time the potato blight struck Ireland, Five Points was known throughout the English-speaking world as a veritable hellhole," Anbinder writes. "Yet the Irish who settled there during the famine years had seen far worse, going months and sometimes years without work and watching friends and family starve before their eyes.

please see ***Neighborhood*** *on page 96*

BMS ABILIFY

P4C

East Side, West Side, All Around the Town: APA's Planned Tours Get You There

Register on site at the Javits Center to take any of 12 tours showcasing New York City while you're in town for APA's annual meeting.

BY MARK MORAN

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.

Tours include the following:

• **Six-Hour Tour of Manhattan:** From uptown to downtown, this tour includes the new Times Square, Madison Square Garden, Greenwich Village, SoHo, Little Italy, Central Park, the Cathedral of St. John the Divine, Grant's Tomb, Harlem, the Museum Mile, Fifth Avenue, Rockefeller Center, Empire State Building Observation Deck, and more.

Sunday, May 2, or Wednesday, May 5, 9 a.m.-3 p.m.; $42

• **Walking Tour of the Upper West Side:** Visitors on this tour of Central Park (Strawberry Fields and Bethesda Fountain), Lincoln Center, and Harlem will learn the history and architecture of Harlem and enjoy a short stop at the African Market for a unique shopping experience.

Sunday, May 2, or Tuesday, May 4, 9 a.m.-1 p.m.; $29

• **Hudson Valley Tour:** From the Convention Center visitors will travel north to the Hudson River Valley. The first stop will be Kykuit, the Rockefeller estate, home to four generations of the Rockefeller family. Kykuit commands breathtaking views of the Hudson River, grand collections of art, 20th-century sculpture, fine furniture, Chinese ceramics, horse-drawn carriages, and classic automobiles.

Monday, May 3, or Wednesday, May 5, 8:30 a.m.-4:30 p.m.; $97

• **Lower Manhattan and Ellis Island:** This tour starts with narrated sightseeing en route to the Battery Park ferry, which will take visitors to Liberty and Ellis islands. The ferry will stop briefly at Liberty Island for an up-close view of the Statue of Liberty. Upon return, visitors will receive a tour of historic Lower Manhattan, South Street Seaport, Brooklyn Bridge, and the site of the World Trade Center.

Monday, May 3, or Wednesday, May 5, 8:30 a.m.- 2:30 p.m.; $57

• **Walking Tour of Lower East Side:** Put on your comfortable walking shoes for this tour of Manhattan's Lower East Side. Get an insider's view of Greenwich Village, Chinatown, and Little Italy.

Monday, May 3, 10:30 a.m.-2:30 p.m.; Wednesday, May 5, 9 a.m-1 p.m.; $29

• **Harbor Cruise:** Enjoy a two-hour harbor tour of Manhattan from Midtown on the West Side around the southern half of Manhattan to Midtown on the East Side.

Monday, May 3, 1 p.m.-5 p.m.; $43

• **West Point:** This tour will travel north along the Hudson River to the U.S. Military Academy at West Point, home to more than 4,000 cadets and staff. The fully narrated tour of West Point's 16,000-acre campus overlooking the Hudson River includes stops at the Parade Ground, the Chapel, and Trophy Point.

Tuesday, May 4, or Wednesday, May 5, 8 a.m.-4 p.m.; $92

• **Midtown Manhattan:** This tour includes the 42nd Street architectural corridor from the United Nations, Grand Central Terminal, Chrysler Building, and New York Public Library into the revitalized Times Square. It also includes Rockefeller Center, Radio City Music Hall, St. Patrick's Cathedral, Channel Gardens, Trump Tower, and Fifth Avenue. The tour ends with a visit to the Observation Deck of the Empire State Building for a spectacular view of Manhattan.

Tuesday, May 4, 9 a.m.-1 p.m.; $38

• **Walking Tour of SoHo:** Explore the SoHo neighborhood with its unique cast-iron buildings, art galleries, and boutique shops.

Tuesday, May 4, or Wednesday, May 5, 11 a.m.-3 p.m.; $27

• **Garment District Shopping and Walking Tour:** On this walking and shopping tour of the famous garment district, showroom visits may include outerwear, accessories, sportswear, and designer clothes at wholesale pricing. Brands and showrooms are subject to availability at time of tour.

Tuesday, May 4, 1 p.m.-5 p.m.; $76

• **Dinner Cruise:** Enjoy an evening of entertainment, dinner, and dancing while cruising around Manhattan and enjoying its picturesque skyline.

Tuesday, May 4, or Wednesday, May 5, 7 p.m.-11 p.m.; $119

• **Museum Mile:** This is a guided tour of the Metropolitan Museum of Art and the Guggenheim Museum. Participants will have free time to do their own exploring afterward.

Wednesday, May 5, 9 a.m.-3 p.m.; $75

The tours are provided through Event Transportation Systems. All tours will depart from, and return to, the Javits Center and require a minimum of 30 people.

The deadline for advance registration has now passed, but APA members may still participate in the tours by purchasing tickets once they arrive at the annual meeting. Tickets will be on sale at the Tour Desk, located in the Javits Center lobby. Reserved tickets may also be picked up at the desk. ■

ROSENBAUMKELLER)

ISL 4C

No Backing Off

As physicians stand by helplessly, our national health care system has changed dramatically over the past three decades. We've watched as managed care organizations with legislative authorization have diverted billions of dollars away from patient care to windfall profits. Nowhere have these changes been more dramatic or more destructive than in the field of psychiatric medicine.

In the face of these powerful destructive forces, physicians have turned to their national organization in search of an ally. We seek to strengthen our voice in the national debate to ensure that our perspective is heard for the benefit of our patients. I was therefore shocked and disheartened when I learned in the February 6 issue that "APA President Marcia K. Goin, M.D., and Medical Director James H. Scully Jr., M.D. . . . have secured the support of New Mexico Gov. Bill Richardson for medical board oversight of psychologists' prescribing." Now with the input of APA's top officials, the nation has a plan authorizing "safe" prescribing practices for psychologists.

The battle by psychologists for prescriptive authority has received an enormous boost. This disaster prompted me to write Drs. Goin and Scully requesting they resign so APA can disavow their endorsement of organized psychology's agenda. But how could this have happened?

In talking with Dr. Goin, she explained her reasoning. I appreciate and respect her opinions, but doesn't our leadership have a responsibility to represent us? We've listened for years to candidates claiming that APA has to become more responsive to the needs of its members. How can it be that the national organization has become so disconnected from the individuals it exists to represent? Without a national organization to champion our views, how can we hope to shape our nation's health care policy? If APA doesn't represent us, how can we support it?

RICHARD KAYE, M.D.
Suffolk, Va.

APA President Marcia Goin, M.D., responds:

APA's opposition to psychologist-prescribing attempts is longstanding, well-documented, and resolute. In every state, in every venue, at every chance, and in every way possible, APA is actively working with our district branches (DBs) and state associations (SAs) to vigorously oppose such schemes because they put patients at risk. Even in the wake of the New Mexico prescribing law, we continue to succeed in these efforts.

Over our strong objection, New Mexico passed a psychologist-prescribing law. APA members know that APA's leadership committed very significant technical and financial resources to that battle, and the leadership and members of the DB there have ready access to APA resources and senior staff as they continue their struggle against this unwise and dangerous law.

We haven't backed off, and we won't. Our work continues on multiple tracks:

- Across the country, we are vigilant in lobbying against psychologists' attempts to win prescribing privileges and in providing our DBs and SAs the resources they need to fight these battles locally.
- In New Mexico, we are working with the Psychiatric Medical Association of New Mexico (PMANM) to respond to the pending regulations to implement the program—not because we approve of the law or believe it can be "fixed," but because we have an obligation to the safety of patients to highlight the deficiencies in the implementation proposal that was recently approved by the joint psychology-medicine board charged with developing the proposal.
- APA is at work with the PMANM and the medical school on an outreach program to ensure that patients in the rural parts of the state receive the quality medical psychiatric care they deserve.

Our meeting with New Mexico Gov. Bill Richardson had nothing to do with any proffered compromise. Rather, this was a timely opportunity to let the governor know of our deep concerns about a law he inherited from his predecessor.

I'm glad Dr. Kaye shared his anxiety over the situation in New Mexico. I share his deep concern, and I am committed to considering all appropriate responses in every venue to this most unwise threat to safe patient care. ■

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.

Board

continued from page 7

Medicine to acknowledge this field's increasing prominence. The Board deferred a decision on what committees will be subsumed within the new council pending discussions between members of the new council and the Joint Reference Committee on what the most useful committee structure would be.

In addition, the Board heard Charles Curie, M.A., director of the federal Substance Abuse and Mental Health Services Administration (SAMHSA), describe the agency's priorities and programs. He stressed that he sees a critical role for APA in the "transformation" of the U.S. health care system from its current fragmented and gap-riddled state to the far-better one described last year in the President's New Freedom Commission on Mental Health report. Curie noted that SAMHSA's Fiscal 2005 budget request contains $44 million in new money for state grants focused on reforming health care delivery. ■

FDA

continued from page 1

depression or suicidality, especially at the beginning of therapy or when the dose either increases or decreases."

At the February meeting, the agency's advisory committee recommended that the FDA proceed with its proposed reanalysis of self-harming behaviors during clinical trials involving antidepressants. However, committee members also strongly felt that the need to strengthen warning language for the medications was urgent enough to change the labeling without waiting for the results of the reanalysis. The FDA has said the reanalysis, which is being done by suicidality experts at Columbia University, should be completed by mid-summer, and the agency plans to hold another public advisory committee meeting to determine whether the results support the newly strengthened warning language or whether the labeling of the medications needs to be changed further.

The medications whose labels will be changed to include the new warnings are fluoxetine (Prozac); sertaline (Zoloft); paroxetine (Paxil); fluvoxamine (Luvox); citalopram (Celexa); escitalopram (Lexapro); bupropion (Wellbutrin); venlafaxine (Effexor); nefazodone (Serzone); and mirtazapine (Remeron).

The warning language adds that "[a]nxiety, agitation, panic attacks, insomnia, irritability, hostility, impulsivity, akathisia (severe restlessness), hypomania, and mania have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although the FDA has not concluded that these symptoms are a precursor to either worsening of depression or the emergence of suicidal impulses, there is concern that patients who experience one or more of these symptoms may be at increased risk for worsening depression or suicidality. Therefore, therapy should be evaluated, and medications may need to be discontinued, when symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms."

The new warnings also cite the possibility of a discontinuation syndrome, advising that certain medications should be tapered rather than stopped abruptly.

In a prepared statement, APA President Marcia Goin, M.D., said APA hopes the advisory and new warning language will lead to better dialogue between physicians, patients, and their families.

At the same time, Goin added, APA is concerned that publicity around the advisory may cause some successfully treated patients to stop taking antidepressants and may block other patients who need help from getting the treatment they deserve.

"Physicians and patients," Goin said, "must work together to weigh the risks and benefits of any course of treatment." What is needed, she added, "is more good science. We reiterate our call to the FDA to develop mechanisms to enhance access to data from clinical trials on SSRI antidepressants, including negative trials, as well as all unpublished research."

Extensive information on antidepressant use in children, adolescents, and adults is posted online at <www.fda.gov/cder/drug/antidepressants/default.htm>. ■

international news

Hot Spots

continued from page 33

cold night, and 'expecting' to be taken care of the way your mother took care of you as a child (regression). . . . In a sense, regressing gives us psychological nutrition. . . . Regression and progression are part of normal daily life for most of us. It is only when regression becomes stubborn and long lasting that we speak of psychological difficulties."

Regression can also take place in a large group when the group feels anxious or traumatized, Volkan continued. These are some of the signs of large-group regression: the group rallies blindly around the leader; the group creates a sharp "us and them" division between itself and the enemy; the group blurs reality and engages in magical beliefs (for example, some Germans under Hitler thought that he was a reincarnation of Siegfried, the heroic figure of ancient German literature); the group becomes preoccupied with minor differences between itself and the enemy .

"We can. . . say that bin Laden and his organization were in a regressed state when they committed the attacks of September 11, 2001," he said.

In general, well-functioning democratic societies are nonregressed, and totalitarian societies are regressed, Volkan asserted. However, societal regression can occur in democratic societies as well—for example, after a massive trauma.

After 9/11, there were some signs of regression in American society, Volkan explained. For example, Americans rallied around their leader, as evidenced by the extraordinarily high approval ratings accorded President George W. Bush; some Americans engaged in magical thinking, viewing the attacks as divine punishment for sinful acts; and some Americans viewed all Muslims, not just bin Laden's group, as the enemy.

On the whole, though, regression did not reach a pathological level, Volkan pointed out. And President Bush's appeal to American youngsters to donate money to Afghan children probably helped keep them from viewing Muslims as the enemy.

Nonetheless, when government leaders take an "us versus them" stance or focus on "evil countries," it could be construed as a symptom of regression, Volkan declared. "This is unfortunate," he added, "because a different approach, one that acknowledges and addresses the complexity of world affairs (while still realistically protecting Americans), would increase human values and promote civilization itself."

Finally, a regressed large group can move out of its regression under the guidance of a good leader, Volkan concluded. Signs of progress include valuing freedom of speech, a fair legal system, halting the devaluation of women, re-establishing family ties as more important than political ties and the personality of the leader, and raising a new generation of children with basic trust.

Barbara Young, M.D., of Philadelphia was one of the psychoanalysts who heard Volkan's presentation. "What I came away with," she told *Psychiatric News*, "was the impression that he and his colleagues were able to use psychoanalytic principles to understand the conflict that pervades at the negotiating table and thus can help to discharge or at least diminish it. . . . I found his presentation both interesting and hopeful in that perhaps there is a way to make progress in the many difficult situations worldwide. Perhaps this can be one of the valuable contributions that applied psychoanalysis can offer at this time." ■

ASTRAZENECA SEROQUEL

P4C

ASTRAZENECA SEROQUEL

P4C

ASTRAZENECA SEROQUEL
P4C

Soldiers

continued from page 25

the 98th CSC had acute stress reactions to combat-related attacks on them or their convoys. Their symptoms including nightmares, insomnia, excessive guilt, anxiety, and an exaggerated startle response. These symptoms typically remitted in less than one week with treatment, said Cardona.

Occasionally, there were exceptions. For example, after a soldier saw the violent death of another soldier during a convoy attack, the experience triggered troubling memories of how a family member had died, memories that interfered with his ability to carry out his duties.

"The soldier avoided driving the truck, where he was located after the attack. He was placed in a restoration unit for four days and then returned to his unit. His nightmares continued, and he became increasingly depressed and ultimately suicidal, even though he was receiving medication and changes were made to his work detail," Cardona said.

The soldier required hospitalization and medical evacuation to Landstuhl Regional Medical Center in Germany, Cardona added.

The number of soldiers evacuated from Iraq for mental health problems nearly doubled between September 2003 and last January. In September, 478 soldiers were evacuated, and by January between 800 and 1,000 soldiers were evacuated for mental health reasons. They were treated at Landstuhl Regional Medical Center in Germany, Cardona stated.

Of the total soldiers evacuated from Iraq, 5 percent to 10 percent were based in northern Iraq, where 20 percent of U.S. soldiers were stationed at the time, he noted.

The suicide rate for U.S. soldiers in Iraq last year was higher than the average entire Army rate for last year, according to a new report released last month by an Army Mental Health Assessment Team. The team interviewed soldiers in Iraq between last August and October, according to the report.

At least 24 soldiers committed suicide in Iraq and Kuwait last year. Cardona said there were no suicides in the northern region, where he was based.

The Mental Health Assessment Team's count equates to a suicide rate of 17.3 per 100,000 soldiers, which is higher than the entire U.S. Army's rate of 12.8 suicides per 100,000 soldiers last year.

The team's official number did not include three soldiers who committed suicide when they returned to the United States.

Investigators found a pattern among the soldiers who committed suicide—they faced personal financial problems, failed personal relationships, and legal problems, according to the report. The investigators also found that the soldiers tended to avoid seeking help for stress or mental health problems out of concern about being stigmatized.

The team recommended placing more psychiatrists and mental health professionals in Iraq and Kuwait and training soldiers to recognize signs of mental health problems using the buddy system.

One reason that the Mosul region may not have had suicides was the CSC's decision early on to focus most of its resources on meeting the mental health needs of the majority of soldiers who were having interpersonal problems rather than combat-related stress reactions, Cardona said.

"We focused on managing soldiers already experiencing mental health problems or needing treatment for psychiatric disorders," Cardona stated.

The Army's Mental Health Assessment Team report review of suicides (Annex D) is posted online at <www.armymedicine.army.mil/news/mhat/annex_d.pdf>. The U.S. Army's "4Health Deployment Guide," written by military psychiatrists, is posted online at <www.hooah4health.com/deployment/familymatters/emotionalcyle.htm>; the American Academy of Child and Adolescent Psychiatry's "Facts for Families," a publication for families in the military, is posted at <www.aacap.org/publications/factsfam//88.htm>. ■

Patient Safety

continued from page 24

tent of your experience with each patient, your knowledge of the patient, the severity of the patient's suicidality, and the extent to which physician-prescribed medications may be of significance to the patient.

- Communicate with other health care professionals about the medications that are being prescribed by all physicians involved in the patient's treatment and about concerns related to the patient's suicide risk.
- Put in place a procedure for safely processing prescription refills. Staff members in your office should know when it is not acceptable to get refill orders routinely for some patients. Refill prescriptions for other psychiatrists' patients with care. Review such refills with the psychiatrist if possible. Where such review is not possible, consider prescribing only enough medication to cover the patient until the psychiatrist returns or can be consulted.
- Education and instruction about the risk of overdose, etc., should be part of the informed-consent process about medications in all patients, particularly those with suicidal behaviors.
- Document the evaluation of the risk of access to lethal means and methods of self-harm, plans for restricting access, and instruction to patients and significant others.

Step 4: Implement the strategy

Incorporate the evaluation of lethal means and methods of self-harm as a standard part of the assessment and treatment of patients with suicidal behaviors. Take appropriate actions to restrict access to lethal methods.

Step 5: Evaluate the strategy

Incorporate the continuous evaluation and improvement of these strategies for reducing suicide risk for patients in your practice. ■

Primm

continued from page 1

At Hopkins, in keeping with her community psychiatry focus, Primm has overseen an outreach program that provides Assertive Community Treatment to patients with severe and persistent mental illness; the Hispanic Clinic, which serves Baltimore's rapidly growing Hispanic population; an outreach program to senior-citizen apartment buildings; and an outreach program that provides services to people who are homeless and mentally ill.

As effective tools in her community psychiatry outreach efforts, Primm has developed two videotapes: "Black and Blue: Depression in the African-American Community," which features first-person accounts by African Americans who have dealt with depression and the stigma they faced in getting help for it; and "Gray and Blue: Depression in Older People," which focuses on elderly individuals who describe their experiences with depression.

A goal of both videos was to "reduce stigma and promote early help seeking," she pointed out. "By using the medium of videotape, mental health information is accessible to a broader audience, regardless of literacy level."

As for her new role heading APA's minority affairs department, Primm said her overriding goal will be to work toward "eliminating mental health disparities for underserved ethnic and racial groups." A major component of these efforts will be to serve as a liaison to APA's Council on Minority Mental Health and Health Disparities and its eight components, most of which represent underrepresented populations.

She emphasized that she will also devote considerable effort to implementing recommendations developed by the APA Steering Committee to Reduce Disparities in Access to Psychiatric Care. As part of such an effort, Primm plans to visit areas of the country "that have large concentrations of medically underserved ethnic and racial groups. My highest priority [in making these visits] will be to reach out to a broad range of groups and individuals, including, but not limited to, APA members, . . . other mental health professionals, legislators, and advocacy organizations."

Primm hopes that these visits will provide opportunities for her to educate people about the problems caused by disparities in mental health care, exchange ideas, and develop strategies that will lead to improving the quality of mental health care for minority Americans.

Primm also sees a role in heightening psychiatrists' awareness about the ethnic and cultural characteristics of their patients. "They need to learn about the ways in which [minority] populations are unique from an economic, social, medical, and historical point of view," she noted. "They should take stock of their own ethnic and cultural backgrounds, as well as biases they may hold toward groups different from their own. Psychiatrists should seek out information about how to maximize the quality of care they provide these groups, including how best to communicate to optimize treatment and patient outcomes."

She hopes she'll be able to convince her colleagues that a "one-size-fits-all" approach to treatment is counterproductive to patient satisfaction and the delivery of quality care.

Primm said she developed an interest in psychiatry at an early age. "I always enjoyed listening to people and helping people with their problems. Psychiatry was my favorite subject in medical school, both during the basic science years and the clinical ones."

She noted that her physician-father was trained as an anesthesiologist but has long been a leader in the substance abuse field, in HIV and AIDS initiatives, and in social medicine.

"I am certain that his work influenced my choice of a career in community psychiatry," she said. ■

LILLY SYMPOS (USTUN)

ISL 4C

Inhalant Use

continued from page 31

able to most children in schools and at home, are highly addictive and toxic.

Inhalant users have also been known to suffer extensive brain damage, Volkow pointed out, because the toxins in inhalants dissolve the myelin sheath surrounding neurons.

"These substances accumulate in the white matter" of the brain, she said, and their effects are "similar to what you see in certain instances of multiple sclerosis." Deafness, blindness, tremors, and permanent personality changes are just some of the brain-related problems caused by inhalant use or abuse.

"These substances, when inhaled, can cause deaths by multiple mechanisms," she said, by triggering arrhythmia of the heart, which can lead to cardiac arrest, or through asphyxiation.

According to Harvey Weiss, who is executive director of the NIPC, about 125 inhalant deaths are reported to the organization each year, though he suspects there are more.

In June 2001 David Manlove, a 16-year-old student at Lawrence Central High School in Indianapolis, Ind., became one of the growing number of youths to die from inhalants.

Manlove's mother and father, Marissa and Kim Manlove, appeared at the press conference to talk about their son's struggle with addiction, his death, and their quest to prevent other inhalant-related deaths.

When David was 15, the Manloves discovered that David had a substance abuse problem, and "after several painful and tearful confrontations," said Kim, "he agreed to seek treatment with us at Fairbanks, a drug-treatment center."

It was there that David began attending meetings and "acknowledging publicly that he was struggling with addiction," Kim said, "and began passing regular drug screens that were part of the contract he had with the treatment facility and us. . . .

"Ironically and tragically," he continued, "David's desire to pass his drug screens may have been one of the reasons he began using inhalants."

Days after he finished his sophomore year of high school in June 2001, David went swimming at a friend's house. He and another friend left to buy computer cleaner at a nearby store and returned to the pool, where David began huffing the aerosol and diving underneath the water to intensify the high. After his second or third dive, he failed to surface, according to Marissa.

After about 45 seconds, David was hauled out of the water. Upon hearing the news, Marissa arrived with David's older brother, Josh, and was "greeted by a sight that is a parent's worst nightmare," she said. "My beautiful boy, stretched out on a gurney, with the paramedics frantically conducting CPR."

At a nearby hospital, paramedics continued their attempts to revive David, unsuccessfully. "With Josh and I standing next to David's lifeless body, we asked the team to stop," she said.

Through a memorial fund, the Manloves have produced a video about their son and his death from inhalants. In recent months, they have been showing it to churches and schools in the community.

"We can't change what happened to David, but we can try to make a difference in the lives of those who could be touched by addiction and inhalant use," said Kim

More information about the NIPC and facts about inhalant use are posted online at <www.inhalants.org>. ■

Neighborhood

continued from page 86

The Irish did not come to Five Points expecting streets paved with gold. They simply wanted work—work that would enable them both to feed their families and to put a little something away so that someday their children could have a better life."

Five Pointers also played hard. There was a carnival atmosphere to Five Points, with the Bowery on the neighborhood's eastern edge the center of the spectacle.

Walt Whitman extolled the Bowery as "the most heterogeneous mélange of any street in the city; stores of all kinds and people of all kinds are to be met with every forty rods. . . .You may be the President or a Major-General, or be Governor, or be Mayor, and you will be jostled and crowded off the sidewalk just the same."

The Bowery was home to the Bowery B'hoys, a subculture of dandy-toughs that flourished for a while by making a name for themselves as lovers of adventure and excitement. (Bowery B'hoys were touted for acts of courage during the Mexican War and were among the first New Yorkers to leave for California during the gold rush.)

A number of inexpensive playhouses sprouted on the Bowery and Chatham Street that catered to the working class, and bare-knuckle prize fighting, among other spectacles, became a Five Points trademark.

After the Civil War, the neighborhood changed, and by 1890 even the name Five Points had dropped from usage. Reform efforts by missionary groups, out-migration of residents to better sections of the city or the country, and the depletion of the male population by the Civil War had changed the face of the neighborhood.

Today, the only 19th century immigrant group that has stayed in the neighborhood is the Chinese. Five Points, Anbinder writes, has become Chinatown.

The story of Five Points is emblematic. "From 1607 to 2001 and beyond, would-be Americans have arrived from abroad, adjusted to the often harsh realities of their lives, and set to work," Anbinder writes. "The Five Points story, at a certain level, is common to us all. . . . There may never again be another slum quite like Five Points, but as long as the United States remains a nation of immigrants, the outline of the Five Points story will never die."

Ordering information for Anbinder's book*, Five Points: The 19th Century New York City Neighborhood That Invented Tap Dance, Stole Elections, and Became the World's Most Notorious Slum, *is posted online at <www.penguinputnam.com/Book/BookFrame/0,1007,,00.html?id=0452283612>. Additional information on the Five Points neighborhood is posted online at <http://r2.gsa.gov/fivept/fphome.htm>. ■