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PSYCHIATRIC NEWS

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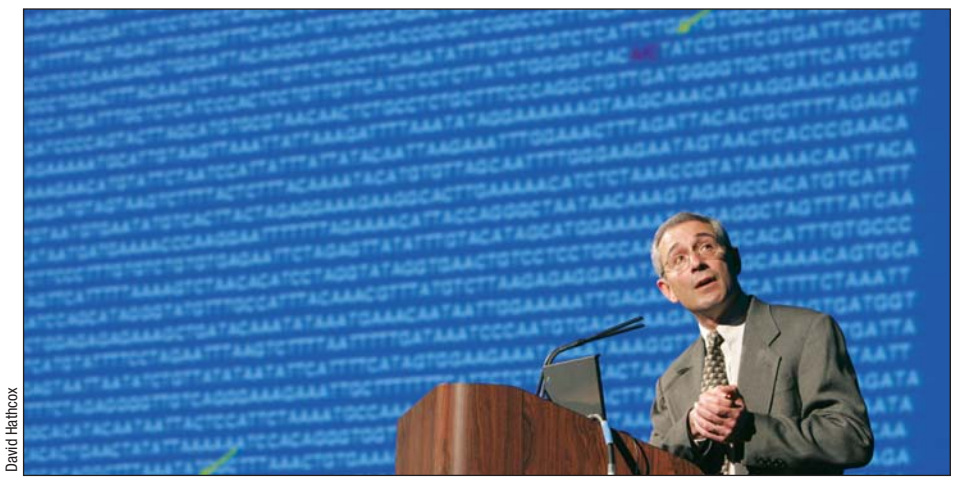


David Hathcox

Against a backdrop of genetic code, Thomas Insel, M.D., tells psychiatrists at APA's 2005 annual meeting in Atlanta that in the not-too-distant future, they will be able to treat patients based on their unique genetic variations. Insel is the director of the National Institute of Mental Health. See page 12.

Government News

Medicare Part D Plans Likely To Cover Most Psychiatric Meds

APA is "cautiously optimistic" that patients with mental illness covered under the new Medicare Part D prescription drug benefit will have broad access to most psychotropic medications. However, there are some important exceptions.

BY JIM ROSACK

Prescription drug plans participating in the new Medicare Part D prescription drug benefit must include "all or substantially all" antidepressant and antipsychotic medications on their preferred drug lists.

That directive came last month from the Centers for Medicare and Medicaid Services (CMS) in the "Frequently Asked Questions (FAQs)" section of its Web site in answer to the question "Why is CMS requiring 'all or substantially all' of the drugs in the antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant and HIV/AIDS categories?"

The FAQ was posted in response to significant concerns and questions raised since January, when the agency issued its final guidance to prescription drug plans (PDPs) on the development of Part D formularies *(Psychiatric News*, March 4). While trying to answer some questions, however, CMS seems to have raised some new ones.

In the final guidance, CMS noted that its "expectations are that best-practice formularies contain a majority of drugs within the following classes: antidepressants, antipsychotics, anticonvulsants, antiretrovirals, immunosuppressants, and antineoplastics. Following common best practices, CMS will check to see that beneficiaries who are being treated with these classes of medications have uninterrupted access to all drugs in that class via formulary inclusion, utilization management tools, or exceptions processes. When medically necessary, beneficiaries should be permitted to continue utilizing a drug that is providing clinically beneficial outcomes."

While the FAQ suggests that patients will have access to a variety of psychiatric drugs, it has no bearing on the exclusion of benzodiazepines from Part D coverage. That exclusion is mandated by the law that created Part D, the Medicare Modernization Act of 2003. As this issue went to press, Rep. Benjamin Cardin (D-Md.) introduced HR 3151 to reverse the exclusion of benzodiazepines. More information on the bill will appear in the next issue.

After the FAQ was posted, questions quickly arose regarding its language. For example, what does "contain a majority of drugs" really mean? CMS acknowledged that in training sessions and phone calls, PDPs had asked for an explanation of how a formulary could meet the "inclusion" standard expected by CMS while continuing to make use of "utilization management tools or exceptions processes." In short, critics said, the policy appears to be contradictory.

CMS said in the FAQ that it has "consistently explained that [the policy] meant that access to all or substantially all drugs in these specific categories needed to be addressed by plan formularies."

The FAQ goes on to say that "'substantially all" in this context means that all drugs in these categories are expected to be included in plan formularies, with the "specific exceptions noted" at the end of the

please see ***Medicare*** *on page 30*

Professional News

AMA Opposes Restrictions On SSRI Use In Youngsters

The House of Delegates adopts an APA-AACAP resolution endorsing the training of investigators to study the effects of psychotropic drugs in children, adolescents, and young adults.

BY MARK MORAN

Selective serotonin reuptake inhibitors (SSRIs) should remain available for use in children and adolescents, including for unlabeled uses, according to a report adopted by the AMA House of Delegates at the organization's annual policy-making meeting in Chicago last month.

The report was written by the AMA's Council on Scientific Affairs (CSA) in response to a resolution brought to the house at last year's meeting by APA and the American Academy of Child and Adolescent Psychiatry (AACAP).

The report also states that current clinical evidence indicates that fluoxetine is an effective SSRI in children and adolescents with major depressive disorder, and it calls for a review of how FDA regulatory actions impact prescribing patterns, patient compliance, and access to medications.

"A causal role for antidepressants in increasing suicides in children and adolescents has not been established," the CSA report states.

The council's report was adopted without debate on the floor of the house and had widespread support from pediatricians and other physicians during reference committee hearings. Along with several other actions that originated with the APA Sec-

please see ***AMA*** *on page 29*

Capuccino Catering, Chicago

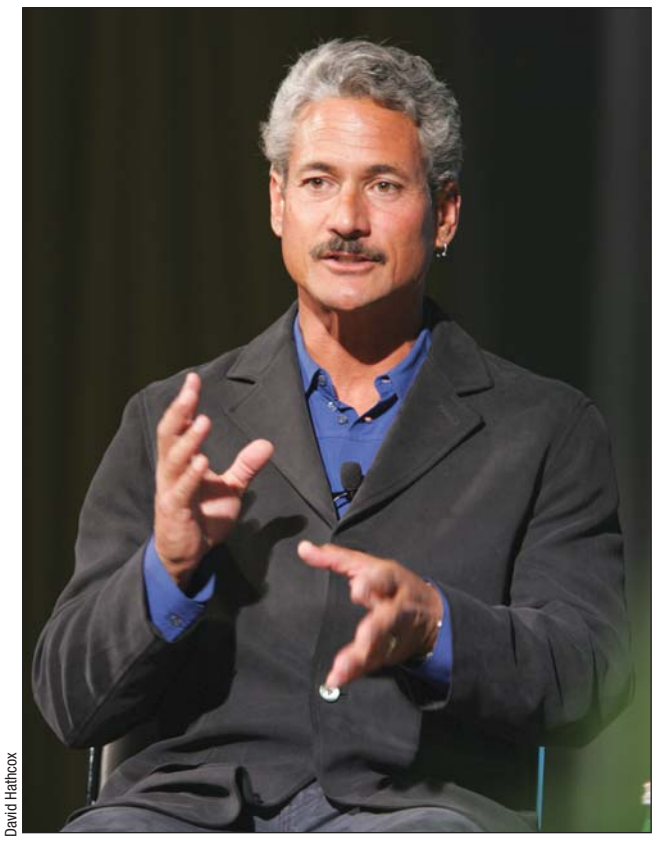
Carolyn Robinowitz, M.D. (left), greets well-wishers at a reception in her honor after she was reelected to AMA's prestigious Council on Scientific Affairs (now the Council on Science and Public Health). Robinowitz is APA's secretary-treasurer.

Former Olympic Gold Medalist Discusses Battle With Depression

A young man who seemingly had so much going for him found it hard to swim against the current of depression.

BY TARA BURKHOLDER

More than 500 people attended a discussion between Olympic gold medalist Greg Louganis and former APA President Mary Jane England, M.D., at the American Psychiatric Foundation's fourth annual "Conversations" event held at APA's 2005 annual meeting in Atlanta. The two discussed Louganis's history of depression, substance abuse, abusive relationships, and HIV infection.



David Hathcox

Greg Louganis shares his story at the American Psychiatric Foundation's "Conversations" event at APA's 2005 annual meeting.

For a long time, Greg Louganis appeared to have it all. At the 1976 Olympic games, when he was 16, he won a silver medal, and at 24 he was the first man in 56 years to win two gold medals in diving by winning both the platform and springboard events. But unbeknown to his worldwide audience, Louganis was suffering from depression.

His depression was driven by late-detected dyslexia, prejudice about his dark skin color, and ambivalence about his sexual orientation, he said. Louganis told England that a lot of his success came from a desperate place. He felt that to be worthy of love, he had to win. Louganis said that when he won the silver medal, instead of feeling pride, he felt disappointment. Without the gold medal, he felt as though he had failed.

Louganis's coping mechanisms included staying busy and getting plenty of exercise. In a follow-up interview with the APA News Network, he said, "I had my dance, acrobatics, gymnastics, and diving to keep me physically active, which I think helped in basically my survival."

He learned that he was HIV-positive in 1988 as he prepared for the Olympic games in Seoul. For years, he did not talk about it out of fear that it would cost him his diving career. Eventually, he went public with his HIV status and began touring the country to share his life experiences.

Today Louganis spends much of his time speaking to youth groups, drug and alcohol rehabilitation groups, and organizations that help people with dyslexia. His autobiography, *Breaking the Surface*, was first published in 1995 and spent five weeks at the top of the *New York Times* bestseller list.

"Conversations" is supported by a grant from AstraZeneca Pharmaceuticals. The foundation launched the series at the 2002 annual meeting in Philadelphia to provide an opportunity for psychiatrists to hear from people whose lives are touched every day by mental illness. The event is conducted as an interactive interview to allow for freer conversation between the featured guest and an interviewer. Previous speakers included Tipper Gore, Carrie Fischer, and George Stephanopolous. ■

Tara Burkholder is the American Psychiatric Foundation's marketing communications manager.

WPA to Meet in Cairo

The XIII World Congress of Psychiatry, organized by the World Psychiatric Association, will be held in Cairo from September 10 to 15. The congress offers a rare opportunity to learn from experts in psychiatry from all over the world, to share knowledge with colleagues, to socialize, and to visit Cairo's and Egypt's cultural jewels.

Further information is posted online at <www.wpa-cairo2005.com>. ■

Every Psychiatrist Needs To Be an Advocate

BY STEVEN S. SHARFSTEIN, M.D.

For more than 30 years, I have happily paid my APA dues. My membership in the national APA and my local district branch has been part of my identity as a psychiatrist and my commitment to professional standards and ethics that transcend economic self-interest. It is one way of giving back. I believe my membership in APA has served as a means to express my views in the political marketplace and to develop an advocacy agenda that puts my patients and access to quality care first. Now, as president of this wonderful organization, I plan to make advocacy the central theme of my year in office.

The *Oxford English Dictionary* states that "to advocate is to publicly defend, maintain, recommend, stand up for, or raise one's voice on behalf of a proposal. . . . " As psychiatric physicians, I believe we are the natural advocates for our patients because of our special, hard-earned knowledge and expertise and our sacrifice and commitment to putting patients first. Medicine needs a strong APA today more than ever.

The American health care system is in crisis. Americans are the least satisfied health care consumers in the English-speaking world. Despite the fact that we spend more than any other country on health care (approaching 15 percent of the gross domestic product), we are doing worse. According to the World Health Organization, life expectancy in the United States measured in healthy years ranks 29th in the world, between that of Slovenia and Portugal. With the number of uninsured Americans now at 45 million and growing, and the number of underinsured at many millions more, especially for mental health care, one can see the dimensions of the crisis that led President Bush's New Freedom Commission on Mental Health to declare "the mental health system is in shambles."

Since 1980 American health care has radically changed. Before then we were a system that was largely not for profit, driven by the doctor-patient relationship and in the public interest. Over the last quarter century, we have succumbed to market-driven strategies—for-profit, corporatized, managed health care. Publicly held corporations accountable to Wall Street and stockholders ration care in America where the for-profit health maintenance organizations (or managed behavioral health care companies) decide who receives care, how much care one can receive, whether one can see a specialist, how long one stays in the hospital, how many therapy sessions one receives, and what medications one may take—and these decisions apply to the lucky individuals, those with health insurance. Those without insurance are out luck.

We have the world's largest, costliest health care bureaucracies, estimated to cost in the tens of billions of dollars. There is colossal administrative waste in our system today, which includes countless hours spent by the average American health care consumer on the telephone correcting billing mistakes, arranging medical appointments, obtaining tests, and getting referrals. It also includes the time and expense of dozens of billing specialists at hospitals and doctors' offices trying to collect from the more than 1,000 insurance plans that people have and hope will actually cover their expenses, not to mention the hours spent on the phone or filling out forms justifying "medical necessity."

There is basic anxiety among Americans about access to health care. If they have health insurance, they worry they will lose it. If they don't have health insurance, they know they are close to financial ruin. The most common cause of personal bankruptcy in America today is medical expenses.

APA's agenda for advocacy must be to fight for the integrity of the medical system and the public health. Advocating for universal access to health care and parity of benefits along with utilization-review methods for psychiatric and other medical conditions is not only just, it is a moral imperative that also makes sense clinically and financially.

At the national level, APA has one of the finest government relations teams among medical specialty organizations, but APA's advocacy also depends on our district branches as more and more health decisions are made in state capitals, and that means we need you, as individual physicians and members, to step out of your office and get into the political arena for the good of our patients and our profession.

Articulating the case for access to quality psychiatric care is the advocacy leadership I ask of each of you. Today, to paraphrase President John Kennedy, it's not enough to just pay your dues and ask APA to do the advocacy for you. What can you do for APA and our patients? Being a member of APA is a calling to always do more. If you are interested in getting involved, please contact me at SSharfstein@sheppardpratt.org. ■

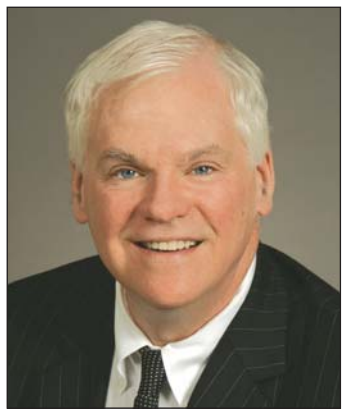
Nominations Invited For Weinberg Award

APA's Council on Aging invites nominations for the 2006 Jack Weinberg Memorial Award. The award was established to honor the late Jack Weinberg, M.D., a past president of APA and a longtime leader in the field of geriatric psychiatry. The award is given to a psychiatrist for special leadership or outstanding work in clinical practice, training, or research initiatives in geriatric psychiatry anywhere in the world. The deadline for submission is July 31.

Further information is available from Emory Rogers at (703) 907-8575. ■

APA Uses Multiple Strategies To Eliminate MH Disparities

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



While there have been substantial advances in mental health treatment in recent years, one area in which we still have a lot of work to do is in eliminating the disparities that often characterize the care received by those who are members of racial or ethnic minority groups, are elderly, or live in rural areas.

A large portion of the 46 percent of Americans who suffer from a mental disorder at some point in their lifetime but receive no or inadequate treatment are in one or more of these population groups. Several years ago, in response to a national challenge to help reform and repair the nation's crumbling mental health system, APA unveiled a blueprint for mental health care titled "A Vision for the Mental Health System." This blueprint includes the principle that mental health care should be patient and family centered, community based, culturally sensitive, and easily accessible without discriminatory administrative or financial barriers or obstacles.

The Office of Minority and National Affairs (OMNA) has responded to the blueprint by developing various strategies to eliminate mental health care disparities and implementing recommendations in APA's "Action Plan to Reduce Mental Health Disparities for Racial and Ethnic Minorities."

OMNA's mission—to meet the professional needs of minority psychiatrists and improve the quality of care for underserved people—is being fulfilled through new strategic plans under the leadership of Annelle Primm, M.D., M.P.H. Thanks to OMNA staff and APA minority councils, caucuses, and committees, our members are able to expand their reach into communities across the country through new initiatives to increase diversity in the psychiatric workforce; inspire and recognize minority psychiatrists and those from underrepresented groups; and serve as a clearinghouse for information on mental health care disparities.

Here are just a few examples of how OMNA is working on behalf of our members and the communities we serve.

• OMNA's long history of promoting and helping to recruit a culturally competent and diverse psychiatry workforce is evident in numerous programs. These include the Minority Fellowships Program in conjunction with the Substance Abuse and Mental Health Services Administration and AstraZeneca, GlaxoSmithKline Leadership Program, Jeanne Spurlock Congressional Fellowship, Minority Medical Student Summer Mentoring Program, and Summer Externship in Addiction Psychiatry. These programs have supported more than 600 psychiatry residents, fellows, and medical students. OMNA is also working to expand further the pool of psychiatry fellows through the new Minority Fellowship on Gay, Lesbian, and Bisexual Mental Health, for which it is seeking funding support.

• OMNA teamed up with the Division of Education and Career Development last October to release a dynamic recruitment video that has proven to be a highly effective marketing tool for the field of psychiatry. "Real Psychiatry: Doctors in Action" is a half-hour video that was developed to increase the diversity of the psychiatric workforce and raise awareness about mental health issues in patients from diverse backgrounds (*Psychiatric News*, January 21). Copies of the video on either DVD or VHS are free and can be ordered by sending an e-mail request to dvd@psych.org.

• The OMNA on Tour initiative was launched earlier this year as a series of town-hall-style meetings to inform underserved communities about mental health disparities and their impact on overall health, economic productivity, and societal well-being. The meetings produce collaboration among stakeholder groups in developing local action plans to eliminate mental health disparities. The tour began in Washington, D.C., in January *(Psychiatric News*, March 4) and will continue later this year with stops in Memphis and the Delaware Valley area.

• Earlier this year OMNA convened a roundtable on racial and ethnic disparities with 25 mental health advocates from government agencies, mental health organizations, and consumer groups to develop recommendations in support of APA's initiative to reduce mental health care disparities among racial and ethnic minorities *(Psychiatric News*, May 6). This effort yielded recommendations for expanding the role of minorities in mental health research and the publication of best-practice guidelines for mental health services for minority and underrepresented groups. These and other recommendations will be made available in the future on a section of the APA Web site dedicated to OMNA initiatives.

I encourage every APA member to ask: "What can I do to make a difference in these communities?" You can make a difference by, for example, supporting an OMNA event in your community and by volunteering to serve as a mentor to a minority medical student or resident. Members who are black, Asian American, Hispanic, American Indian/Alaska Native/Native Hawaiian, international medical graduates, women, or gay, lesbian, or bisexual may choose to join one of the APA minority caucuses representing the concerns of these groups.

As your Association, we value your ideas, support, and membership! ■

MIT Trustee-Elect

Recommendations for candidates for the position of APA member-in-training (MIT) trustee-elect are now being sought. The MIT position is a two-year commitment. The resident elected in the 2006 election will serve on the Board for one year without a vote (May 2006 to May 2007) and then advance to the MIT trustee position with a vote (May 2007 to May 2008).

Position requirements are posted online at <www.psych.org/edu/res_fellows/mitnominees.cfm>. Applicant information may be submitted at this site.

The deadline for receipt of submissions is August 5. Further information is available from Carol Lewis by phone at (703) 907-7852 or by e-mail at clewis@psych.org.

Professional News

Foundation Benefit Financial, Artistic Success

The American Psychiatric Foundation's annual benefit proved to be an excellent mix of fine art, southern cuisine, and highly successful fund raising.

The benefit, whose theme was "Georgia on My Mind," was held May 21 at the High Museum of Art in Atlanta. The event, held the evening before the APA annual meeting's opening, brought together clinicians, mental health care administrators, advocates, and patients to further efforts of the foundation and APA to spread the message to the public that mental illness is not only real, it is treatable.

The evening turned out to be quite successful, taking in more than $160,000. Support came from both individuals and corporations. A silent auction brought in an additional $2,500 that will go to the artists whose works were featured and sold.

Each of the artists who contributed works to the silent auction is a patient at Skyland Trail, a nationally recognized mental health treatment facility in Atlanta. The foundation invited Skyland Trail to cohost the benefit after the facility won the APA 2004 Psychiatric Services Gold Achievement Award for its outstanding and innovative community-based treatments.

More information on the foundation is posted online at <www.psychfoundation.org>. Information on Skyland Trail is posted at <www.skylandtrail.org/>. ■

Governors Seek Escape Route From Medicaid Funding Crisis

Governors want more flexibility to decide who gets what in terms of Medicaid benefits and lower costs for prescription drugs.

BY KATE MULLIGAN

In testimony presented on Capitol Hill last month, the National Governors Association (NGA) offered a plan to reform the Medicaid program that seems to contain something to please and to offend nearly everyone.

NGA Chair Mark Warner (D), governor of Virginia, and Vice Chair Mike Huckabee (R), governor of Arkansas, presented a bipartisan proposal that aims to restrain expenditures and provide governors more flexibility to administer the program. The NGA noted in written testimony that it is "difficult to overstate the impact of Medicaid on state budgets." On average, Medicaid accounts for about 22 percent of a state's budget and is the largest single item of expenditure.

Even more important, however, are trends that portend a worsening of the fiscal dilemmas that Medicaid currently poses for state officials.

The program, which is funded jointly by the federal and state governments, increasingly serves populations with "very serious and expensive health care needs," such as individuals with serious mental and physical disabilities. The proportion of older people and persons with disabilities, who already account for 70 percent of Medicaid's $330 billion annual budget, will grow considerably over the next 20 years.

The overall Medicaid caseload has increased 40 percent over the past five years. Some of that increase can be linked to a decline in the percentage of people under 65 covered by employer-provided insurance.

In addition, the Medicaid program, like all other insurers, has been faced with rising costs of health care. According to the NGA, the consumer price index for health has been increasing at a rate two to three times that of the average price index.

The result will be a three-pronged attack on the capability of states to fund Medicaid and maintain their own financial viability.

In "Medicaid Reform: A Preliminary Report," the NGA provided extensive recommendations that address both short- and long-term problems with the program.

The NGA wrote, "For individuals with disabilities who have no other recourse than to rely on Medicaid, reforms should encourage more consumer choice and benefit packages that improve the quality of their care where possible. . . ."

In a later section, the NGA challenged the validity of a law prohibiting copays for some populations and services and restricts the amount of copays for other populations.

Instead, the NGA advocated "broad discretion [for the states] to establish any form of premium, deductible, or copay for all populations, for all services. . . . " Some financial caps would apply.

States, in fact, have already begun to promote "consumer choice" and to increase copays for Medicaid beneficiaries (see article below).

The NGA also noted problems with the distinctions between "mandatory" and "optional" populations. For a state to participate in Medicaid, it must serve "mandatory" populations and provide "mandatory" services, according to the current law.

But, the NGA pointed out, many relatively healthy children and families technically are in mandatory populations, and many of the optional populations are among the "frailest" in the program.

For more "medically fragile populations," the NGA advocated increased chronic-care management and other services that can improve health outcomes and reduce costs.

The NGA also recommended "more tools" to encourage home- and community-based care and the elimination of the need for a waiver to provide those services.

The NGA's recommendations concerning costs of prescriptions drugs have earned the most publicity. The NGA wrote, "States and the federal government have long suspected that Medicaid overpays for prescription drugs."

It offered a multipronged attack on those prices that includes the following recommendations:

- Increasing the minimum rebates that states collect on brand-name and generic drugs.
- Forcing discounts on the front end of drug purchases rather than waiting an average of six months to receive rebates.
- Using closed formularies to drive beneficiary utilization and decrease costs similar to those that will be used in the new Medicare Part D plans.
- Allowing states to join multistate purchasing pools and to combine Medicaid with other state-funded health care programs to improve leverage.

The Pharmaceutical Research and Manufacturers of America (PhRMA) responded to the recommendations by claiming that drug costs "make up only 14 percent of Medicaid's expenses this year," according to an article in the *Hill* on June 21.

Jeffrey Young, in the same article, reported that Rep. Heather Wilson (R-N.M.) said, "We need to make these types of changes." Wilson led a Republican Energy and Commerce Committee working group on Medicaid in 2003.

Families USA, a major health advocacy organization, issued a written statement calling the proposal a "mixed bag." The organization applauded the efforts to decrease the costs of prescription drugs and supported proposals to improve access to home- and community-based care.

But, Ron Pollack, its executive director, expressed concern that increased premiums, deductibles, and copayments could "make health care services unaffordable. . . ."

He also argued that it "made no sense" to enact structural changes in Medicaid before policy changes are carefully examined. Congress is requiring up to $10 billion in Medicaid cuts over the next five years.

Rep. Joe Barton (R-Tex.), chair of the House Energy and Commerce Committee, said, "I applaud the governors and generally support the reforms they are bringing to us," according to the June 16 *New York Times*.

Some Democrats, including Sen. John Kerry (Mass.) and Sen. Jay Rockefeller

please see ***Governors*** *on page 30*

N.J. Bucks National Trend, Enhances MH Services

New Jersey officials move ahead with mental health reform, while other states add copays and new restrictions on access to medications for Medicaid beneficiaries.

BY KATE MULLIGAN

New Jersey Acting Governor Richard Codey (D) signed an executive order last month to implement some of the recommendations of the Governor's Task Force on Mental Health submitted to him on March 31 *(Psychiatric News*, May 20).

The order authorizes expenditures of $250,000 to establish the Governor's Council on Mental Health Stigma. That body will develop and implement a master plan to increase public awareness and understanding of mental disorders.

The order also elevates the profile of mental health within the state government by creating the position of special assistant commissioner for mental health services and expands access to the state's mental health hotline so residents can get help from a clinician 24 hours a day, seven days a week.

Fate of Oregon Parity Bill Uncertain

Oregon's Senate passed a parity bill (S 1) in June that got "caught up in the deal making of the last days of the Legislative Assembly," reported the *Oregonian* on June 13.

The *Oregonian*, however, had harsh words about the process. "If this sausage making is hard for the public to stomach, imagine how it looks to the exhausted families that have spent themselves into bankruptcy trying to get care for their mentally ill children."

The column, part of a series titled "Oregon's Forgotten Hospitals," describes the struggles of two families to get help for their sons. The unnamed author wrote that the bill "is a declaration that Oregon families should not have to lose everything, even custody of their children, to the hell of a mental illness."

House Republican leaders refused to let the bill come to the floor for a vote and were holding out for concessions on a proposed capital gains tax cut, according to the column.

States Add Medication Limits

Mississippi has imposed additional limits on access to medications for Medicaid beneficiaries, according to the Web site <www.kaisernetwork.org> on June 16.

Under the policy, which was scheduled to take effect July 1, beneficiaries will be allowed prescriptions for five drugs a month, two of which are brand-name medications and three of which are generic medications. Beneficiaries had been allowed up to seven prescriptions a month.

The HIV Medical Association sent Gov. Haley Barbour (R) a letter charging that the policy could result in "substandard HIV care" because generic antiretrovirals are not available, and most HIV/AIDS patients need at least three antiretrovirals to treat the virus effectively.

Restrictions on access to medication also are a part of Tennessee's effort to restructure TennCare, its Medicaid program.

The most recent proposal of Gov. Phil Bredesen (D) to the Centers for Medicare and Medicaid Services (CMS) for changes to TennCare would limit monthly prescription coverage to two brand-name medications and three generic medications and introduce copayments of $3 for brand-name medications for beneficiaries with incomes above 100 of the poverty level. The proposal would permit establishment of a preferred-drug list and limit rights to appeal. Nearly 400,000 adult beneficiaries would be affected by the change.

In Louisiana, physicians prescribing medication for Medicaid patients must receive prior authorization for medications not on a preferred drug list. However, antipsychotic medications and those used to treat hepatitis C had been exempt from these requirements, but last month a bill to eliminate that exemption received final legislative approval. The bill will go to Gov. Kathleen Blanco (D), who is expected to sign it.

South Carolina Proposes Health Accounts

South Carolina submitted to the CMS a plan that would provide Medicaid beneficiaries with personal health accounts to purchase public or private health insurance, according to the Web site <www.kaisernetwork.org> on June 21. The plan would also include higher copayments for services.

The proposal assumes that insurers would offer a variety of plans, ranging from those with low costs and limited services to comprehensive HMO plans. Beneficiaries would receive debit accounts to pay for additional out-of-pocket costs and copays.

For each debit account, the state would earmark an amount similar to the amount state residents spend on private-sector health care.

Michigan Promotes Healthy Lifestyles

The Michigan Senate approved a Medicaid bill that would charge beneficiaries an average $5 monthly premium, but would reduce that premium if a beneficiary agrees to sign a pledge to lead a healthy lifestyle. A healthy lifestyle would include abstinence from tobacco and an annual checkup, for example.

Beneficiaries who are pregnant, are in nursing homes, or have disabilities are exempt from the premium.

The bill would establish a $10 copay for a brand-name prescription medication if a generic is available and a $25 copay for nonemergency visits to emergency rooms.

The Senate failed to approve Medicaid enrollment reductions that were in the House version of the bill. ■

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N.Y. Attorney General Honored For Drug-Safety Crusade

Eliot Spitzer was recognized for his work in ensuring that the public has access to accurate information on drug safety and effectiveness.

APA's prestigious Jacob K. Javits Public Service Award was presented to New York State Attorney General Eliot Spitzer in his office last month.

Each year the Javits Award is given to a public official whose service in office has had a significant, positive impact on the field of psychiatry and the quality and accessibility of mental health care.

"The public and APA are indebted to Attorney General Spitzer for his work to give people greater access to information on the safety and effectiveness of medications," said Tom Noyes, M.D., chair of APA's Committee on Government Relations, which bestows the award. "Through the power of his office, Mr. Spitzer has helped physicians and patients—in New York and all across the country—make more informed treatment decisions. Mr. Spitzer's actions benefit patients no matter what illnesses they confront."

New York State Attorney General Eliot Spitzer (left) poses with Barry Perlman, M.D., president of the New York State Psychiatric Association and a member of APA's Committee on Government Relations, after receiving APA's 2005 Jacob K. Javits Award.

The Javits Award is named for the late U.S. Sen. Jacob K. Javits of New York. Javits, a Republican, served in the Senate from 1957 to 1981 and dedicated his decades-long public service career to issues ranging from civil rights to health care.

Like Spitzer, Javits was a lawyer and attorney general of the state of New York (1954-1957). ■

Bill Barring MH Screenings Defeated

Legislation based on an inaccurate assertion that the 2003 landmark report of the President's New Freedom Commission on Mental Health calls for mandatory screening of children for mental illness and their forced medication without informed parental consent was defeated last month in the House of Representatives for the second year in a row.

The legislation, introduced both years by Rep. Ron Paul (R-Texas), was in the form of an amendment to the House Labor, Health and Human Services (LHHS) Fiscal 2006 legislation (HR 3010). It prohibited the use of federal funds to create or implement a universal mental health screening program.

The amendment was defeated by voice vote and later a recorded vote of 304-97.

APA led the latest effort to secure the legislation's defeat. Paul initially introduced the legislation earlier this year as the Parental Consent Act of 2005 (HR 181). At that time APA and the American Academy of Child and Adolescent Psychiatry sent a letter to members of the House and Senate calling on them to oppose the legislation *(Psychiatric News*, March 18).

Before the vote on the amendment was taken, Rep. Ralph Regula (R-Ohio), chair of the Appropriations Subcommittee on LHHS, spoke in opposition to the amendment, saying that there are no federal funds that can be used for screening without parental consent. He also noted that Mike Leavitt, secretary of Health and Human Services, had testified before the subcommittee that the Bush administration never has and never will support screening without parental consent. ■

APA Leader Meets With Key Senator

Joseph Rubin, M.D., speaker of the APA Assembly, meets with **Sen. Olympia Snowe** (R-Maine) in Portland, Maine. Snowe, who serves on the Senate Finance Committee's Healthcare Subcommittee, introduced the Medicare Co-payment Equity Act of 2005 (S 1152) in the Senate in late May with **Sen. John Kerry** (D-Mass.). The bill seeks to reduce the current discriminatory Medicare 50 percent copayment for outpatient psychiatric services to 20 percent. A companion bill was introduced in the House of Representatives in March. The visit with Snowe is part of an ongoing program at APA—through its political action committee, APA*PAC*—in which APA members educate federal legislators and policymakers about mental health issues.

Courtesy of Sen. Snowe's Office

AMA Endorses Several APA-Sponsored Proposals

The AMA House of Delegates took action on a number of issues important to psychiatry: medical-record privacy, physician access to FDA data, direct-to-consumer ads, Medicare's new prescription drug benefit, and licensure considerations when a physician has depression.

BY MARK MORAN

The AMA will advocate for dropping a section of the U.S. Patriot Act that allows the government to seize patients' medical records while also prohibiting physicians from informing patients about the seizure.

If those sections are renewed by Congress, they should be amended substantially to better protect medical privacy and patient confidentiality, according to an AMA Board of Trustees report approved by the AMA House of Delegates at its annual policymaking meeting last month in Chicago.

The report was written in response to a resolution brought to the house last year by APA and the American Academy of Child and Adolescent Psychiatry (AACAP).

Section 215 of the Patriot Act provides that the FBI may require production of "tangible things" (including books, records, papers, documents, and other items) for an investigation to protect against international terrorism or clandestine intelligence activities. The act further states that "[n]o person shall disclose to any other person. . .that the FBI has sought or obtained tangible things under this section."

At the AMA's interim meeting last December, then APA President-elect Steven Sharfstein, M.D., told delegates that the Patriot Act is unique from other laws requiring disclosure of patient records because of what amounts to a gag order—a provision forbidding the physician from informing the patient or anyone else that records have been taken.

"It would mean the treatment relationship would have to end," Sharfstein said.

Ted Grudzinski/American Medical Association

David Fassler, M.D.: "We have clear and consistent data that [direct-to-consumer advertising] has a significant impact on patient requests for specific medications and on the prescribing patterns of physicians."

The section is scheduled to "sunset" at the end of 2005. The AMA board report suggests that if the section is not dropped altogether, it should be amended in any of the following possible ways:

- The term "tangible things" should be narrowed.
- Only specific, discrete, and relevant portions of patient medical records should be disclosable.
- Patients subject to disclosures should have to be shown to be the focus or target of a terrorist or clandestine intelligence investigation.
- Orders should be issued only with the knowledge of the patient to whom the ordered disclosure pertains.
- The gag provision should be limited to only the most extraordinary circumstances, and the attorney general should be required to disclose publicly order requests and grants on a periodic basis, among other safeguards mentioned above.

Despite some testimony during reference committee hearings that counseled caution when treading on matters related to national security, the House of Delegates passed the report without debate. It was one of a number of items of importance to psychiatry that were readily approved—a sign, APA leaders say, of the continuing and growing influence within the house of medicine of the psychiatry delegation. (See related stories elsewhere in this issue: AMA actions regarding SSRIs in children and adolescents on page 1; and on suicide and depression on college campuses and pay for performance on facing page.)

John McIntyre, M.D., chair of the Section Council on Psychiatry and head of APA's delegation, said the action taken by the house on the Patriot Act is evidence of the AMA's staunch defense of medical privacy.

"This was really an issue affecting the doctor-patient relationship, and it demonstrates the willingness of the AMA to stand in defense of that relationship even in the face of controversy," he said.

The board report states, "Even without hard data, it can be assumed the act will cause some patients to avoid seeking care or to be less than forthcoming in the physician's office. Quality of care may suffer. Unable to protest or even publicly acknowledge a disclosure, medical professionals stand to lose the trust and confidence of their patients and undermine the patient-physician relationship."

Other Actions

These are other items of interest to psychiatry on which the House of Delegates acted:

- **Enhancing access to FDA data:** Also written in response to an APA/AACAP resolution and approved by the house was a report by the Council on Scientific Affairs titled "Enhanced Physician Access to Food and Drug Administration Data."

That report calls on AMA to (1) urge the Food and Drug Administration (FDA) to issue a final rule, as soon as possible, implementing modifications to the format and content of the prescription drug package insert with the goal of making the information more useful and user-friendly to physicians; (2) urge the FDA to collaborate with physician organizations to develop better risk communication vehicles and approaches; (3) urge the FDA to apply new tools to gather data after drugs are approved for marketing, including a broader use of targeted postapproval studies, institution of active and sentinel-event surveillance, and data mining of available drug-utilization databases; (4) monitor the design and implementation of any independent drug-safety board that may be instituted within the FDA, or external to the agency, and respond as appropriate; and (5) support adequate funding to implement an improved FDA postmarketing prescription drug surveillance process.

- **Direct-to-consumer advertising (DTCA):** A number of resolutions on drug marketing to consumers, including one submitted by APA and AACAP, were debated during the meeting. Some of those resolutions called for an outright ban on direct-to-consumer advertising.

The APA/AACAP resolution asks for an AMA report on the subject that would explore strategies for minimizing the potential harmful effects of DTCA. Among these possible strategies is a "quiet period" immediately following drug approval during which advertising would not be permitted, allowing time to monitor patient safety and efficacy.

During reference committee hearings, David Fassler, M.D., the AACAP delegate and a member of the Section Council on Psychiatry, noted that at least one drug company had already voluntarily agreed to such a policy.

All of the resolutions on DTCA were referred to the AMA Board of Trustees with the likelihood that they would be considered together in a report by the Council on Scientific Affairs, as requested by the APA/AACAP resolution.

- **Educating physicians about Medicare Part D:** Rounding out the list of psychiatry-sponsored actions approved by the AMA last month was a resolution requesting the AMA to prepare a report on educational programs for physicians around issues related to the new Medicare Part D prescription-drug benefit. That resolution also asks the AMA to "make available appropriate educational materials targeted for physicians on Medicare Part D issues, so that they may best assist patients and effectively meet their responsibilities under Medicare Part D laws and regulations."

- **Benzodiazepine restrictions under Medicare:** The resolution asks the AMA to "work to end the exclusion of medications of the benzodiazepine class from reimbursement" under the new Part D benefit.

- **Depression and physician licensure:** This resolution asks the AMA to "recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely called into question but instead have decisions about their licensure, credentialing, and recredentialing be based on professional performance."

It further calls on the AMA to make the resolution known to state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing.

More information about these and other actions taken at the AMA's 2005 annual meeting are posted online at <www.ama-assn.org/ama/pub/category/14887.html>. "Enhanced Physician Access to Food and Drug Administration Data" is posted online at <www.ama-assn.org/meetings/public/annual05/csa6a05.doc>. ■

Psychiatrists Reelected to AMA Positions

APA members **Jeremy Lazarus, M.D.,** and **Carolyn Robinowitz, M.D.,** have been reelected to positions they hold at the AMA.

Lazarus, a former speaker of APA's Assembly, was reelected the vice speaker of the House of Delegates. He also serves as chair of the AMA Board Task Force on Medicare/Health System Reform and is a member of the Board Audit and Organization and Operations committees.

Robinowitz, APA's secretary-treasurer, was elected to another term on the AMA's prestigious Council on Scientific Affairs (now to be called the Council on Science and Public Health). The council reports on medical, scientific, and public health issues that affect the practice of medicine, the quality of patient care, and the translation of scientific research into patient treatment. At last month's meeting, the AMA adopted a critical council report on the use of SSRIs in children and adolescents (see story on page 1).

AMA to Develop Guidelines On College MH Care

The AMA action is a victory for APA's initiative on college mental health, one goal of which was to bring the issue of suicide and depression on college campuses to the attention of the AMA.

BY MARK MORAN

The AMA will advocate for developing guidelines on appropriate access to psychiatric and other mental health services on college campuses, as part of a comprehensive report the organization has agreed to prepare on depression and suicide on college campuses.

The AMA House of Delegates last month approved a resolution calling for the report, which will include a review of scientific data on the efficacy of prevention programs aimed at reducing the incidence of suicide on college campuses. The AMA has also agreed to review the data on access to—and utilization of—college mental health services.

The resolution was brought to the house by APA, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the American Academy of Psychiatry and the Law.

The AMA action is a victory for APA's own initiative to address depression, suicide, and other mental health issues on college campuses. In January, Michelle Riba, M.D., then APA president, established the Presidential Task Force on Mental Health on College Campuses, one goal of which was to bring the issue to the attention of the AMA (see box).

Task force co-chair David Fassler, M.D., AACAP's delegate and a member of the Section Council on Psychiatry, told delegates at the meeting that psychiatric illness is increasingly prevalent on college campuses.

"The incidence of significant psychiatric illness, including depression, is increasingly common on college campuses, in part because we are doing a better job of recognizing the signs and symptoms of mental illness at an earlier age," Fassler said. "As a result, more and more young people are coming to college with an existing diagnosis. Some of those young people may not have made it beyond high school in previous generations. The ability to attend college is due in part to early and effective psychiatric treatment.

"We now have close to 16 million college students, and more of these young people need access to comprehensive mental health care, including psychiatric and substance abuse services," Fassler said.

Jeremy Veenstra-VanderWeele, M.D., a resident member of the Section Council on Psychiatry, testified about his own experience as a "dorm parent" working the night shift at the University of Chicago.

"There really is a sense of panic on college campuses about suicide," he said. "The staff members take very seriously any indication for suicide without any knowledge of what to take *very* seriously and what to take *somewhat* seriously. I think our AMA could use its medical knowledge to provide guidance to college staff members who lack our level of clinical training."

Veenstra-VanderWeele added that parents of new college students may not ask about the availability of mental health services on campus or inform staff that their children have been receiving such services, making continuity of care difficult or impossible.

"There really is no clear way to transition these kids into college and into treatment within the new community they are a part of," he said.

"Depression and Suicide on College Campuses" is posted online at <www.ama-assn.org/meetings/public/annual05/425a05.pdf>. ■

Ted Grudzinski/American Medical Association

Jeremy Veenstra-VanderWeele, M.D.: "Our AMA could use its medical knowledge to provide guidance to college staff members who lack [psychiatrists'] level of clinical training" concerning behaviors they should look for in students that might indicate suicidal thoughts or intent.

APA Launches College Mental Health Campaign

APA is sponsoring a campaign this summer to promote mental health on college campuses that will include outreach by APA staff and district branches and state associations to media, colleges and universities, and other interested organizations.

Free information for the public about college mental health issues is posted on APA's consumer Web site, <www.HealthyMinds.org>.

The campaign is part of a larger overall strategy aimed at addressing suicide, depression, and general mental health issues on college campuses. To carry out this work, Michelle Riba, M.D., then APA president, established the Presidential Task Force on Mental Health on College Campuses earlier this year. The task force is charged to do the following:

- Review and summarize the existing data on college mental health and on access to psychiatric services on college campuses.
- Review existing guidelines regarding college mental health and draft a policy statement on the role of the psychiatrist in the delivery of mental health services on college campuses.
- Develop a resource guide on college mental health to identify services that should be available to college students.
- Collaborate with other professional and advocacy groups working on college mental health issues.
- Develop a plan to support psychiatrists who are working in college settings.
- Develop a policy regarding discrimination against college students with mental illness.
- Develop a media strategy to enhance public awareness about college mental health issues.

APA members interested in becoming involved in the campaign locally should send an e-mail to Hillarie Turner, senior communications specialist in APA's Office of Communications and Public Affairs, at hturner@psych.org or contact their district branch or state association.

Pay for Performance Must Be Quality Issue, AMA Says

Reservations about pay for performance are tied to the AMA's long-standing opposition to the current physician payment formula, especially the formula for calculating "sustainable growth rate."

BY MARK MORAN

If pay for performance is a fast-moving train, then the AMA appears to have made a move to ensure it does not become a runaway. Following what was easily the most extensive and exhaustive debate of the AMA's policymaking meeting last month in Chicago, delegates approved detailed principles and guidelines for pay-for-performance programs. The principles and guidelines were part of an AMA Board of Trustees report and follow a white paper produced by a special task force convened last year by AMA Board Chair J. James Rohack, M.D.

During reference committee hearings prior to the convening of the House of Delegates, some physicians clearly expressed the desire that pay for performance—or P4P as it is known in shorthand—would go away. But the majority acknowledged that it is inevitable and focused attention on ensuring that P4P programs are not used as cost-cutting tools by government or private payers to penalize physicians.

"The members of the AMA are strongly supportive of quality-improvement efforts, and pay for performance is a potential quality tool," said AMA Trustee John Armstrong, M.D., in a press conference after the house adopted the report. "But pay for performance must be designed so that the patient remains the focus, and the outcome is quality, using relevant quality-improvement measures.

"Is there a concern about pay for performance? There is a potential concern when there is another intent behind pay for performance," Armstrong said. "Some so-called pay-for-performance programs are a lose/lose proposition for patients and their physicians, with the only benefit accruing to health insurers. We believe that pay-for-performance programs done properly have the potential to improve patient care, but if done improperly can harm patients."

Few ideas in American medicine today are moving with as much momentum as P4P, the concept of paying hospitals and physicians for adhering to practice guidelines and meeting standards for quality improvement. It is part of a broad movement in both the public and private sectors toward the incorporation of "performance indicators," an effort to create greater accountability and transparency in the practice of medicine.

"Pay-for-performance programs done properly have the potential to improve patient care, but if done improperly can harm patients."

Performance indicators are under development by organized medicine, including the AMA, as well as many private health plans, the federal government, and accrediting agencies. The federal Centers for Medicare and Medicaid Services recently announced a demonstration project for pay for performance *(Psychiatric News*, March 18). The concept has been greeted with suspicion by some physicians, however, and a great many uncertainties remain to be resolved before it becomes the norm.

Prominent among the concerns is the fact that public-sector dollars for reimbursing physicians come out of a finite budget, so that increases in payment are

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Mental Illness Treatment Still Elusive for Many

Over the past two decades, NIMH has supported various epidemiological efforts to measure the prevalence of mental illness and its treatment in the United States. The latest effort is the National Comorbidity Survey Replication.

BY JOAN AREHART-TREICHEL

In the past decade, the use of mental health treatment in the United States has dramatically increased. Still, many Americans are not receiving minimally adequate care for mental illness.

That's one of numerous findings from the National Comorbidity Survey Replication (NCS-R), published in the June *Archives of General Psychiatry* in four papers. The NCS-R is a follow-up of the National Comorbidity Survey, whose results provided an overview of Americans' mental health a decade ago.

The lead author of the NCS-R was Ronald Kessler, Ph.D., a professor of health care policy at Harvard Medical School. Other researchers, including psychiatrists, were involved as well.

Although results from the survey are extensive, five major findings stand out:

• Almost half of all Americans (46 percent) will meet criteria for a *DSM-IV* disorder sometime in their lifetime.

"The public and policymakers need to realize that the high prevalence is not surprising," Harold Pincus, M.D., executive vice chair of psychiatry at the University of Pittsburgh and one of the survey authors, told *Psychiatric News*. "All you have to do is think about the people you know—family, friends, neighbors, coworkers—and how many of them go through some significant emotional turmoil over the course of their lives."

• Mental disorders usually have their onset in childhood or adolescence. Such early onset, the researchers wrote, is "opposite the patterns found for almost all chronic physical disorders. . . . Whatever else we can say about mental disorders, then, they are distinct from chronic physical disorders because they have their strongest foothold in youth."

• Although mental disorders are widespread in the U.S. population, the most serious ones are concentrated among a relatively small proportion of cases. Of cases that occur during a 12-month period, about 22 percent can be classified as serious, 37 percent as moderate, and 40 percent as mild. Twelve-month cases were classified as serious if they had any of the following: a suicide attempt with serious lethality intent; work disability or substantial limitation due to a mental or substance disorder; positive screen results for nonaffective psychosis; bipolar I or II disorder; substance dependence with serious role impairment; an impulse-control disorder with repeated serious violence; or any disorder that resulted in 30 or more days out of role in the year.

• While the vast majority of people with lifetime psychiatric disorders eventually receive treatment, the delay in doing so can be long, on average six to eight years for mood disorders and from nine to 23 years for anxiety disorders.

• Survey respondents who had a mental disorder that met *DSM-IV* criteria during the preceding 12 months were asked about any mental health treatment they had received during that time. Only 41 percent reported receiving treatment, and only about one-third of those were classified as having received at least minimally adequate treatment. Minimally adequate treatment was defined as receiving either pharmacotherapy (two months or more of an appropriate medication plus four or more visits to some type of physician) or psychotherapy (eight or more visits with a health care professional lasting on average at least 30 minutes).

Pincus said that he was surprised at "how few people had minimally adequate care—even those seen by psychiatrists, and even those with pretty significant conditions."

Philip Wang, M.D., Ph.D., told *Psychiatric News* that he was surprised by this finding as well. Wang is an assistant professor of psychiatry at Harvard Medical School and one of the survey authors.

"[M]ental disorders. . . are distinct from chronic physical disorders because they have their strongest foothold in youth."

The irony, Wang said, is "that despite the fairly dramatic increase in the use of mental health treatments that has occurred over the past decade, the adequacy of treatments received by individuals really hasn't improved."

Nonetheless, while increased use of mental health treatments does not appear to have benefited the public as a whole, undoubtedly individual patients have improved because of them, Kenneth Wells, M.D., believes. Wells is a professor in residence in psychiatry at the University of California at Los Angeles and one of the survey authors.

"The NCS-R study offers some new exploratory data that, along with other research studies, stand to have an impact on the mental health field and need to be further validated in order to understand the greater implications of the findings," Darrel Regier, M.D., said in an APA press release issued in conjunction with publication of the NCS-R results. "It is important to note that new findings typically need replication and validation."

Regier is director of the APA Division of Research and the American Psychiatric Institute for Research and Education.

"The findings reported here are the first of what promises to be a bountiful harvest," Thomas Insel, M.D., and Wayne Fenton, M.D., wrote in an editorial accompanying publication of the results. "The NCS-R is one element in a coordinated program of new psychiatric epidemiological studies that will be completed over the next several

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certain to be taken from somewhere else. And some fear that P4P can be used to penalize hospitals and physicians that fail to meet performance measures.

Also potentially problematic is that adherence to measures will require ability to track performance over time; physician practices that do not have electronic record collection will have to rely on office personnel to pull and review charts—a labor-intensive exercise that is likely to go uncompensated.

The principles and guidelines adopted by delegates last month mark an attempt to address these and other issues related to the adoption of pay for performance.

At the press conference, Armstrong emphasized that reservations about P4P, particularly as it may be implemented in the Medicare program, are tied to the AMA's longstanding, vociferous opposition to the current physician payment formula, especially the formula for calculating "sustainable growth rate."

That component is built into the payment formula to compensate for increases in utilization of services by forcing a reduction in physician payments. Since introduction of P4P is likely to increase the volume of some appropriate services, the payment formula would then work to penalize physicians inappropriately.

"That formula is flawed at its foundation and does not reflect practice costs in any measure," Armstrong said. "We see the negotiations on the sustainable growth rate as an important focus for access to care, and we see pay for performance as a potential tool for quality."

Ultimately, P4P programs will require up-front resources, especially for technology required to track quality-improvement data.

"Health-information technology requires a significant investment," he said. "Right now in the practice environment we have a flawed Medicare reimbursement formula and a liability crisis. The burdens in practice have become so extreme that it makes it hard for physicians to have the resources to invest in health-information technology.

"We cannot make [P4P programs] yet another unfunded mandate," Armstrong said.

The board report stated, "Physician pay for performance (P4P) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical P4P programs are patient centered and link evidence-based performance measures to financial incentives."

The report went on to enumerate the following five principles by which P4P programs should abide:

- **Ensuring quality of care:** Fair and ethical P4P programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient-care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect P4P program rewards.

- **Fostering the patient/physician relationship:** Fair and ethical P4P programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

- **Offering voluntary physician participation:** Fair and ethical P4P programs offer voluntary physician participation and do not undermine the economic viability of nonparticipating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers.

- **Using accurate data and fair reporting:** Fair and ethical P4P programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment, and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

- **Providing fair and equitable program incentives:** Fair and ethical P4P programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

In addition, the House of Delegates also approved much lengthier and detailed "guidelines" to govern the intricate mechanisms of how P4P programs might work. Broad categories covered by the guidelines include quality of care, physician-patient relationship, physician participation, physician data and reporting, and program rewards.

"Pay-for-Performance Principles and Guidelines" is posted online at <www.ama-assn.org/meetings/public/annual05/bot5a05.doc>. ■

Treatment

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years." Insel is director of the National Institute of Mental Health (NIMH); Fenton is director of the Division of Adult Translational Research and associate director for clinical affairs at NIMH.

The NCS-R was based on interviews of a nationally representative sample of Americans conducted from 2001 to 2003. More than 9,000 subjects aged 18 and older were interviewed using the World Mental Health Survey version of the Composite International Diagnostic Interview, which generates diagnoses of mental disorders in accord with *DSM-IV.*

The study was funded by the NIMH, National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, Robert Wood Johnson Foundation, and John W. Alden Trust.

Abstracts of the four survey papers from the NCS-R are posted online at <http://archpsych.ama-assn.org/cgi/content/abstract/62/6/593>, <http://archpsych.ama-assn.org/cgi/content/abstract/62/6/603>, <http://archpsych.ama-assn.org/cgi/content/abstract/62/6/617>, and <http://archpsych.ama-assn.org/cgi/content/abstract/62/6/629>. ■

Genomics Promises Revolution In Psychiatric Treatment

The challenge today is making the leap between genomic variation and behavioral or functional variation at the level of individuals.

BY MARK MORAN

Breakneck advances in genomics promise to usher in an era of "individualized medicine" based on a thorough understanding of the molecular pathophysiology of mental illness.

So said Thomas Insel, M.D., director of the National Institute of Mental Health, in the Judd Marmor Award Lecture at APA's 2005 annual meeting in May in Atlanta.

Insel sketched a portrait of a not-too-distant future when clinicians will treat precise targets along a pathophysiological chain from genes to cells to distributive systems within the brain based on a patient's unique genetic variation.

This is an ambitious, even visionary, portrait, but one that Insel said is already taking shape in the treatment of cancer, diabetes, and cardiovascular disease. While this vision depends on some technological virtuosity yet to be attained in psychiatric research, he noted that these advances are already being pursued with "breakneck speed."

For instance, merely knowing the location of genes, as was achieved with the completion of the Human Genome Project, is barely a beginning. That accomplishment has been likened to writing the "White Pages," a "text" made up of 3 billion base-pairs of DNA, with every gene having an address and a phone number to locate it within the text.

But what is really necessary, Insel explained, is the "Yellow Pages"—a catalog of where and how genes are expressed and how they function. So a critical research goal is to go "gene by gene along the White Pages, ask if the gene is expressed in the brain, and if so where."

That goal is being advanced by the Gene Expression Nervous System Atlas (GENSAT) Initiative at Rockefeller University, among other places.

And that is not all. Insel noted that scientists possess a "consensus" genome sequence derived from the handful of people who contributed their DNA to the public and private arms of the Genome Project.

But, like the proverbial snowflake, no two people who are not identical twins will ever have the exact same genome. What is really necessary to close the link between the genome and human health or disease is a map of variations across the 3 billion base-pairs of DNA.

"That is the challenge," Insel said, "making the leap between genomic variation and behavioral or functional variation at the level of individuals."

Fortunately, variations in genomic sequence (known as single nucleotide polymorphisms) occur in inherited units known as "haploid genotypes," or haplotypes—meaning that scientists do not have to map all 3 billion base-pairs of DNA for variations; they only have to map the haplotypes.

Spearheading this project is the International HapMap Project, a multicountry effort to identify and catalog haplotypes. The next version of the map is scheduled to be completed this summer, Insel said.

"This tells us for the first time that we can begin to study individual variation at a level and a speed and at a lower expense than we ever thought possible," he said. "The question of how you relate individual variation in sequence to function is now a tractable question."

The upshot of these developments is likely to be transformative.

"Where this may take us is to a very different vision of what psychiatry could look like in a postgenomic era," Insel said. "We are talking about moving us from where we currently diagnose by symptoms and treat empirically to an era where we really do understand something about the molecular pathophysiology of [psychiatric] disorders."

Turning a Paradigm on Its Head

Insel predicted that the current and long-standing strategy by which treatments for mental illness are derived will be looked back on as anachronistic—and somewhat illogical.

Today, he said, the pathophysiology of mental illness is surmised from the mechanism of action of pharmaceutical compounds that are themselves chanced upon serendipitously, as a result of tweaking other formulations already proven successful.

It is a process that stands scientific logic on its head. "It's like trying to find out if the mechanism of aspirin is related to the pathophysiology of headache," Insel said. "Thinking that way is not going to lead you to new discoveries, but to a lot of knock-offs of aspirin. Yet that is very much what has happened in psychiatric research. We haven't had any new classes of compounds in 30 years."

The modern molecular genomic model reverses this paradigm. Already, in areas of research such as cancer, diabetes, and cardiovascular disease, scientists are elucidating specific variations in genetic sequence that result in alterations in cellular and systems functioning; then animal studies are designed to test targets along the chain from genes, to cells, to systems, to function.

"That's the way you get to new classes of drugs—not by taking drugs we already have and modifying them to find a market," he said.

In psychiatry, the task is complicated by the fact that all of the psychiatric conditions are considered "complex" disorders involving multiple genes and multiple brain systems.

The way in which the genomic text itself is "read out" in cells, systems, and functioning is proving more baroque than previously imagined. One curiosity emerging from the completion of the Human Genome Project, for instance, is the relatively small number of genes; of 3 billion base-pairs of DNA, there are just 23,000 genes, or intelligible "sentences" in the text.

A question this raises is the nature and purpose of the great bulk of nongenetic material in the genome, and Insel said much recent research is focused on these noncoding areas: What are they there for? And what are they doing?

Research within the last year reveals that it is in the process of transcription (by which an RNA copy is built from a DNA sequence) and translation (the process by which the RNA copy is translated into the amino acid sequence of a protein) that these noncoding regions play a critical role.

For instance, "promoter" regions of DNA appear to influence where and how much of a protein is read out, so that a variation in a promoter region can have an enormous influence on cell and system function, he said.

For this reason, Insel said it is the complex processes of transcription and translation—not merely the gene itself—that holds the key to understanding how the genetic blueprint expresses itself in cells, systems, and function.

Putting It All Together

Some recent and ongoing research is managing to put all the pieces of this puzzle together, a model for a true molecular genomic understanding of mental illness (see box).

Insel suggested that a midterm goal of this revolution-in-progress would be the development of "biodiagnostics" using, for instance, neuroimaging tools as biomarkers for specific mental illness.

"What we are talking about is developing treatments that go after the core pathology," Insel said.

But the real breadth of his vision for the revolution in molecular neurobiology was suggested in his comments about the "endgame"—when psychiatrists could use

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David Hathcox

Thomas Insel, M.D., says that a "midterm goal" of the revolution now under way in psychiatry is the development of "biodiagnostics" to identify biomarkers for specific mental illnesses.

From Genes to Cells to Systems To Behavior

The pieces of the puzzle are coming together—some of them anyway—toward a true neurobiological understanding of mental disorders, said Thomas Insel, M.D., director of the National Institute of Mental Health (NIMH).

In an address to psychiatrists at APA's 2005 annual meeting, Insel cited recent groundbreaking research from which has emerged the beginnings of a molecular pathophysiology for depression—from genes to cells to systems to functioning.

He described an often-cited study by Caspi and colleagues in the July 2003 *Science* showing that a functional polymorphism in the promoter region of the serotonin transporter (5-HTT) gene was found to moderate the influence of stressful life events on depression. Individuals with one or two copies of the short allele of the 5-HTT promoter polymorphism exhibited more depression and suicidality in response to stressful life events than individuals with the long allele.

"This is a gene-environment interaction, and it suggests one way in which these genetic variations may play out," Insel said.

A new report by psychiatrist Daniel Weinberger, M.D., and colleagues at the NIMH builds on the finding to extend it to structural changes in a specific area of the brain.

In a paper published online in May in *Nature,* Weinberger and colleagues used neuroimaging to show reduced gray matter volume among individuals with the short form of the 5-HTT gene in limbic regions of the brain critical for the processing of negative emotion, especially the perigenual cingulate and amygdala—areas that had previously been associated with decreased volume and changes in metabolism among individuals with depression.

The researchers then performed functional MRI analysis of those regions as subjects were being shown images of a threatening face. In individuals with the long form of the 5-HTT gene, there was increased activity in the perigenual cingulate and amygdala, but in those with the short form there was significantly decreased activity directly related to the variation in temperamental anxiety experienced by subjects.

"The concept is that having this variation along the course of development leads to changes in cells—in this case, cells that express the serotonin transporter," Insel explained. "That could lead to a different pattern in the way connectivity happens in the brain. At the systems level it would give you a very different way of processing negative stimuli and make you vulnerable for a complex disorder such as depression.

"This begins to provide a molecular pathophysiology [for depression] from genes to cells to systems to behavior," Insel said.

Telepsychiatry Bridges Gap In Indian MH Care

Hundreds of miles may separate psychiatrists and patients, but technology links them for evaluation, treatment, and consultation in an innovative program based at the University of Colorado.

BY AARON LEVIN

Practicing psychiatry hundreds of miles away from your patient over a video link means marrying technology and medicine with mundane subjects like funding and credentials, said Jay H. Shore, M.D., M.P.H., an assistant professor of psychiatry at the University of Colorado Health Sciences Center in Denver (UCHSC), at APA's 2005 annual meeting in Atlanta.

The center runs telepsychiatry programs from Denver serving American Indian patients hundreds of miles away in several surrounding states. These services include a posttraumatic stress disorder (PTSD) clinic for north Plains Indian military veterans and a child and adolescent consulting practice at a South Dakota hospital.

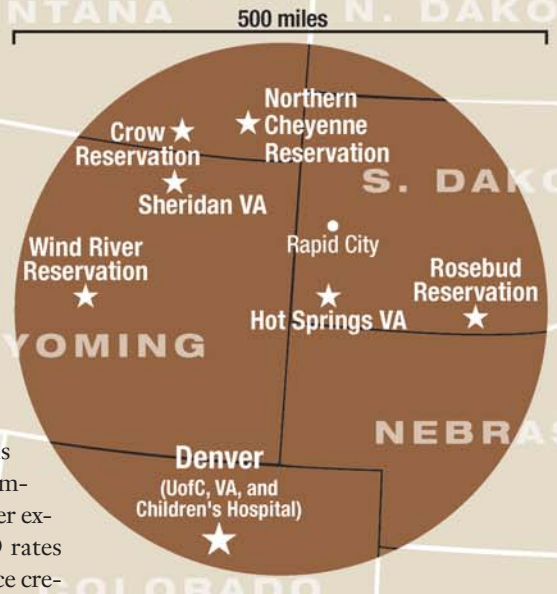
Both services operate with the University of Colorado psychiatrists in a room in Denver, while the patients go to sites equipped with a video linkup near their homes. The Indian Telehealth Network uses an integrated digital services network (ISDN) or a Department of Veterans Affairs intranet, not the open Internet.

"Video conferencing over the Internet is not secure, the quality is not that good, and it varies with the amount of traffic," said Douglas K. Novins, M.D., an associate professor of psychiatry at UCHSC. "ISDN gives us much better quality."

Remote setups for veterans are located at clinics on the Rosebud, Wind River, Crow, and Northern Cheyenne reservations. Trained outreach workers like Gilbert Jarvis help persuade tribal members suffering from PTSD to come to the local clinics for evaluation and therapy. Contemporary telepsychiatry is integrated with a native-healer program that uses sweat lodges, talking circles, and healing ceremonies, said Jarvis, a Shoshone tribal outreach worker and a veteran well connected to the veteran community in rural Wyoming.

"Indian culture says you can't let other people know your problems," said Jarvis, who appeared with the UCHSC doctors in Atlanta. Many would fear exposure if they were seen coming out of a mental health clinic, but are willing to visit a Veterans Affairs center with the proper encouragement, he said. American Indians served in disproportionately large numbers in the military and have had greater exposure to trauma and higher PTSD rates than the U.S. norm, he added. Distance creates a barrier to care because so many also live in remote areas, but outreach workers like Jarvis can connect with the vets and get them to the clinic door.

"We have one 83-year-old who thinks he's a movie star," said Jarvis.



Service Has Built-In Advantages

In the weekly telepsychiatry clinics, the psychiatrists in Denver provide individual therapy, group therapy, and medication management, said Shore. They may take two hours to evaluate a new patient, half an hour for a follow-up session, or one hour for a weekly group therapy session. The program has logged 1,000 patient contacts in two years.

"The biggest goal in the first session is developing rapport with the patient, even if we're not getting at all the issues," said Shore. "Trust is critical."

The tribal outreach workers like Jarvis help with "system transference," vouching for the doctor and cementing the therapeutic relationship. In some ways, the distance between doctor and patient may even help, said Shore: "You won't run into the patient in the grocery store."

The physicians may miss some subtle cues by not being in the room, but they may gain objectivity, he said. Doctors can tolerate more intense affect: the patient may get angry, but therapy needn't stop. Nonetheless, they must establish protocols covering what to do when the line goes down in the midst of a session with a suicidal patient.

Service Fills Gap for Child Psychiatrists

The separate child psychiatry program operates in cooperation with the Sioux San Hospital in Rapid City, S.D. A former Public Health Service tuberculosis sanatorium, Sioux San is operated by the federal Indian Health Service. Sioux San's last child psychiatrist left in 2001 after eight years. Currently, no child psychiatrists work for the Indian Health Service in North Dakota, South Dakota, Iowa, and Nebraska, the four states Sioux San serves.

Obstacles to telepsychiatry arose when it was first proposed after 2001, said Novins. The hospital could offer no funds to support the program, but federal funds were found for a pilot demonstration project, and the project moved ahead.

The UCHSC group hesitated to provide direct child psychiatric services at first. However, the Sioux San staff was experienced in general psychiatry and envisioned telepsychiatry as adding specialist expertise to its own work.

"For us, the telepsychiatry program essentially serves as a second opinion," said adult psychiatrist Mark Garry, M.D., Sioux San director of behavioral health, in an interview. "We usually have pretty good idea of what's happening with a patient, but the system can confirm that or offer a different opinion or treatment plan."

Patients in Rapid City have already seen Garry or another psychiatrist before the telepsychiatric consultation. Each patient receives an 80-minute initial evaluation by the UCHSC team assessing the child and a caregiver. Those sessions are followed by 40-minute case discussions with local doctors, nurses, and social workers. The telepsychiatry group performed 21 evaluations in its first year, most extremely complex, given Sioux San's status as a tertiary hospital, said Novins.

"Patients and caregivers said it helped to have their own clinician in the room and to know that an expert was involved," said Novins. "Clinicians reported that the UCHSC group helped with diagnoses. They learned by watching the child psychiatrists and felt less isolated and more comfortable seeing these patients."

The child psychiatrists in Denver said they took longer to establish rapport with patients over the video link and found the session less emotionally satisfying and harder to remember. There was an average of one disconnection per session, which added to the sense of discontinuity, said Novins.

Technical problems remain the biggest concern for Garry in Rapid City, who recounted three line failures in one session on the day he spoke with *Psychiatric News*. "You can be in a long, sensitive discussion with a patient when the line goes down, so you need a technical person who can get things reconnected quickly."

He noted, however, that he and the other general psychiatrists at Sioux San can usually maintain the discussion in the room during any outages.

Technical issues aside, patients and their families say they are satisfied with the program. Adolescents sometimes relate to the screen and camera even better than to a clinician in the room, said Garry. "They look at it like another video game."

Some Barriers Remain

The operating costs of the UCHSC telepsychiatry system were less than six face-to-face consultations a year ($744 versus $932), but the $8,500 in initial equipment costs represented a significant difference. Allocating those hardware costs among other disciplines would ease the financial burden.

"It's hard to convince other UCHSC providers to use the system," said Shore. "If we could spread the fixed costs across multiple clinics, the cost per unit would drop."

Although the demonstration funds ran out in February, Sioux San eventually funded the fixed costs and uses the equipment to consult with a small Indian reservation.

Money is only one issue that must be addressed for telepsychiatry to work, said Shore. Nearly as much administrative time goes into the project as clinical time, he said. Licensing for physicians working across state lines is another question. Psychiatrists treating veterans can sidestep that since they fall under the federal umbrella, but some system of shared state licensing, national licensing, or limited telemedicine licensing is needed in the long run, he said. Integration inside and outside the system is essential, he added.

"You need to develop both the technology and the program in parallel," he said. "And you need cooperative, dedicated people at both ends."

Further information is posted online at <www.uchsc.edu/ai/cnatt/cnattindex.htm>. ■

Massachusetts District Branch Honors Outstanding Members

Several Massachusetts psychiatrists were recently honored by their district branch, the Massachusetts Psychiatric Society (MPS), for outstanding contributions to their field.

The winners of the 2005 Outstanding Psychiatrist awards were (from left in photo) **Ross Baldessarini,** M.D., **John Herman, M.D., Alan Brown, M.D., Aaron Lazare, M.D., Leon Eisenberg, M.D.,** and **Carola Eisenberg, M.D.** Not pictured are **Elizabeth Childs,** M.D., **and Maurizio Fava,** M.D.

The awards were presented at the MPS's annual meeting in May at Bentley College in Waltham, Mass. The keynote speakers were two state legislators, **Sen. Steven Tolman** and **Rep. Ruth Balser.** The two co-chair the legislature's Joint Committee on Mental Health and Substance Abuse.

Balser discussed the continuing legislative efforts to gain full parity for mental health care, and Tolman focused on the need to draw attention to the substance abuse problem, particularly that involving abuse of prescription drugs, among young adults.

Ellen Callaway

Clubhouse Members Design Their Road to Recovery

In the second of a two-part series about Horizon House, staff explain their rehabilitative approach. The first part appeared in the May 20 issue.

BY KATE MULLIGAN

One constant in the 50-year history of Horizon House, a multiservice mental health center headquartered in Philadelphia, is the struggle to find ways of meeting the needs of each individual who comes for services.

Efforts to translate that core concept into practice are highly visible at Providence House, a clubhouse in Chester, Pa., that is one of the agency's many programs.

"Many people don't understand the clubhouse model," said Courtney Smith, the director. "They think it's just a drop-in center, where people come to sit around."

To receive certification from the International Center for Clubhouse Development (ICCD), however, a clubhouse must meet standards set by a committee made up of members and staff of ICCD-certified clubhouses from around the world.

Those standards promote self-determination and respect for the capabilities of members as a means of promoting their recovery.

Membership is voluntary and open to anyone with a history of mental illness, unless the person poses a significant and current threat to the general safety of the clubhouse community. There are no agreements, contracts, schedules, or rules intended to enforce participation of members.

Members and staff work side by side and are involved in all aspects of clubhouse operation. All meetings are open to both groups. The clubhouse offers transitional, supported, and independent employment outside the clubhouse.

"You don't just 'do clubhouse,' " said Smith. "It's a whole culture in which everyone is valued. We don't focus on the illness."

Creating that culture is a daily enterprise that requires a constant emphasis on promoting empowerment of clubhouse members (see box).

How, for example, does staff approach the issue of medication compliance? "We would help a member advocate for him- or herself with the doctor about side effects or other problems," said Smith. "But no one would be barred from clubhouse for noncompliance unless it is an issue of danger."

No staff member is hired without member approval, and staff evaluations soon will include member comments.

Smith has traveled a long road to get to Providence House. Beginning in 1979, he worked for 15 years as a case manager in a joint effort between Columbia University medical school and Harlem Hospital to provide community-based treatment.

He remembers that period as a time when a patient released from the psychiatric ward of the hospital often had no place to live and was offered medication and little else in terms of treatment or support

"We were telling people what to do," he said. "We weren't helping them find a way to get better."

Smith moved to Philadelphia and worked in another capacity at Horizon House until he earned a master's degree in human services.

Richard Ziegler, director of Delaware and Chester County Services for Horizon House, can trace his professional involvement with the mental health system back nearly three decades.

Two decades of that experience took place as a Horizon House employee. He now has overall supervisory responsibility for Providence House, as well as various housing programs in both counties and a mobile psychiatric service that provides services to consumers in a setting of their choice.

Ziegler can recount a long list of efforts to involve recipients of mental health services in the decisions that affect them.

Recently, staff convened separate focus groups of consumers and family members as part of their preparation for a response to a Request for Proposal from the Delaware County Office of Behavioral Health. That agency undertook a competitive process to select an organization to operate a Program of Assertive Community Treatment (PACT).

"It's the same approach we use when developing an individual service plan," Ziegler said. We ask, 'What will work for you?' "

He said common themes emerged from the two groups. Family members and recipients of mental health services emphasized the importance of "caring, competent staff" and of continuity of PACT team members. They worried about "staff burnout" and low pay. And they urged flexibility in providing services and supports.

Horizon House, which ultimately received the contract, includes a peer specialist as part of its PACT team. Peer specialists are or have been recipients of mental health services.

Their involvement in the provision of mental health services raises issues about roles, said Ziegler, but they bring an important perspective to treatment.

He was also part of an earlier effort to provide community-based support for people who were discharged from Haverford State Hospital when it closed in 1998.

"We went to the hospital and talked with them about what they wanted," Ziegler said. "Many of them wanted to be in single-person apartments, rather than group homes." They recognized their need for privacy and the problems that can result when another resident regresses.

Horizon House offers a variety of living arrangements in Chester and Delaware counties that include varying degrees of staff supervision in supported and permanent housing. Approximately 100 individuals are served in those programs.

Section 8 vouchers, which are funded through the U.S. Department of Housing and Urban Development (HUD) and authorized by the U.S. Housing Act of 1937, are key to the provision of many of those opportunities for low-income people with mental illness. A recipient of a Section 8 voucher pays 30 percent of his or her income as rent, with public funds paying the remainder.

Ziegler said, "There is not nearly enough adequate and affordable housing now. It's difficult for anyone to remain healthy who is living in an unsafe environment. Any cuts to the program would hamper our ability to serve people with serious mental illness."

Like Horizon House CEO Jeffrey Wilush, however, Ziegler believes that resources must be flexible, as well as adequate.

"We need the ability to use resources in ways that work for the consumer," he said.

Information about Horizon House is posted at <www.hhinc.org>. ■

Clubhouse Member Describes Her Journey Forward

June Sams responded with a one-word answer when asked for the secret of Providence House's success.

"Empowerment," she said.

Sams went on to describe her own experience with the clubhouse. "I was very depressed and spent a lot of time sitting at home in my bathrobe." She didn't want to go to a day-hospital program and was reluctant at first when a social worker at a local hospital suggested Providence House.

"My husband told me, 'Your insecurities are showing,' " she said.

But Sams soon undertook progressively more difficult responsibilities at the clubhouse. She began with the daily newsletter and recently was asked to compile the monthly and annual reports that document use and activities at the clubhouse. A self-described "computerphobic" upon her arrival, she now fills in spreadsheets.

Sams also contributes in ways that express her creative nature and interest in different cultures. She reenacts historical figures at various holidays throughout the year at Horizon House events and is a member of the organization's Cultural Diversity Council.

"You learn how to live and go forward," she said. "You learn how to live with your problems."

Sams emphasized that those lessons apply to everyone, not only to clubhouse members. She participates in the NAMI Walk each year to make a public statement that people with mental illness look like everyone else.

After two years at Providence House and a period in a supported-education program, Sams is ready to go forward. Her goal is to get a full-time job as a peer specialist at Horizon House.

Program Overcomes Obstacles To College Education

Students with mental illness are emerging from a supported-education program in Philadelphia with good job prospects and renewed hope for the future.

BY EVE BENDER

For new college students, adjusting to academic demands and new social situations can be difficult. For those with serious mental illness, however, these aspects of undergraduate life can seem like insurmountable obstacles.

They're not. That is the philosophy behind Education Plus, a supported-education program designed to help people with serious mental illness earn associate's, bachelor's, and master's degrees by providing them with psychosocial and academic support.

Education Plus is a program of Horizon House, a Philadelphia mental health agency that operates a variety of psychiatric rehabilitation programs, including a supported-employment program (see story above and in June 3 issue).

"Education Plus is helping people to bypass entry-level jobs so that they can embark on successful careers," the program's director, Arlene Solomon, M.S., told *Psychiatric News*.

Education Plus was established in 2002 with funding from the Pew Charitable Trust and the Philadelphia Office of Mental Health. Services are free to people with mental illness who live in Philadelphia. Students come to Education Plus through referrals from one of the Horizon House rehabilitation programs, local psychiatrists and mental health professionals, college disability offices, and other sources. The majority of students in the program have schizophrenia, schizoaffective disorder, bipolar disorder, or major depression, Solomon noted.

Students are assigned to one of two educational specialists who meet with them once every week or two during the semester, usually on the student's campus. Together they discuss the student's educational goals and begin to tackle issues that may hamper his or her ability to meet those goals.

Academic Pressures Magnify Symptoms

GinaMarie Centanni, an educational specialist and Education Plus coordinator, helps students manage their time effectively, communicate with their instructors, and cope with anxiety around exam time, she said.

"Procrastination is a big problem with our students," she acknowledged.

Whether in high school, college, or graduate school, most people can recall waiting until the last minute to begin an assignment and pull an "all-nighter" to hand it in on time, but these tactics can exacerbate psychiatric symptoms, Centanni noted.

"Our students can make themselves sick by placing extra pressure on themselves, and when they don't get the assignment done, some students slip into depression and stop going to class."

Part of Centanni's job involves helping students to cope with psychiatric and other medical problems, medication side effects, and problems that arise with housing or family members.

Challenges Are Formidable

Students are faced with formidable challenges. "We had one woman who was living in a homeless shelter with her two children while attending classes," Solomon recalled.

Mornings are the worst time of day for some Education Plus students, Centanni noted, because that is when they most often hear voices or feel fatigued from their medications. In these cases, Centanni advises them to register for afternoon and evening classes.

The majority of Education Plus students need special accommodations to succeed in their courses.

This may, for example, mean having a classmate take notes for them during a brief psychiatric hospitalization, providing them with extra time to finish an exam, or allowing them to take a test in a room by themselves to concentrate better. Some must bring fluids in class to alleviate dry mouth.

Centanni said she regularly refers students to the campus disability office, which offers services such as career or course-selection advice. It is through the disability office that many

*See **Obstacles** on page 30*

Courtesy of Racheal Winters and Horizon House Inc

The staff of the Education Plus program in Philadelphia notes that people with serious mental illness can achieve their educational goals with academic and psychosocial support. From left: GinaMarie Centanni, Arlene Solomon, M.S., and Susan Edwards.

Education Plus Helps Dream Come True

In May "Christine Jones" stood before a group of peers and staff from the Education Plus program to express her gratitude a week after receiving her associate's degree from the Community College of Philadelphia.

Education Plus is a supported-education program offering students with mental illness the academic and psychosocial support they need to reach their educational goals (see article above).

Without Education Plus, she acknowledged, "I'm not sure I could have graduated."

The confidence she gained through the program enabled her to go from "waking up and watching TV all day to earning good grades and acting in a play at college."

Jones, 46, told *Psychiatric News* that she entered college as a freshman at Drexel University in 1975.

High school had not been a good experience for her, she admitted. "I was depressed. After high school, I thought college would be the answer." Her depression worsened after she received a failing grade, and she began to withdraw from her classes before she eventually stopped taking classes altogether.

Jones, who has bipolar disorder, said that for years after she left school, she "lived an isolated life" and felt the world was an "untrustworthy place."

"I always had a vague desire to return to college, but the realization of that dream resided somewhere in the distant future," she said.

At the suggestion of her psychiatrist, Jones began taking classes at a community college a couple of years ago and registered with its Center on Disability, where she learned about Education Plus.

Gradually Jones noticed that her self-esteem improved, and she began to feel connected to those around her.

According to Jones, education specialist Sue Edwards, M.A., "constantly reminded me of my abilities when I could only see my disability." She also described Edwards as "a great sounding board not only about school-related issues but general life issues."

Of the Education Plus support group, Jones said, "I felt relaxed among people who were struggling with similar issues. . . .I was no longer isolated."

Jones now has plans to get her bachelor's degree in psychology at a school in the Philadelphia area. "I feel like I've lived this life of mine for a reason," she said. "A certain knowledge has been borne out of my experiences, and I can empathize with others in my situation. I want to be able to give back."

Innovative Therapy Shows Efficacy in Complicated Grief

Researchers test a psychotherapeutic approach designed to help people who are experiencing complicated grief come to terms with the death of their loved one.

BY EVE BENDER

A new type of psychotherapy created specifically to target symptoms of complicated grief appears to be more effective than interpersonal psychotherapy at helping patients recover after the death of a loved one.

Researchers at the University of Pittsburgh Medical Center are hopeful that complicated grief will be listed as a disorder in *DSM-V*, which is scheduled to be published around 2011.

Complicated grief occurs after the death of a loved one, and symptoms (which persist for more than six months after the death) include a sense of disbelief about the loved one's death, anger and bitterness over the death, yearning for the deceased person, and preoccupation with thoughts of the loved one, including distressing intrusive thoughts related to the death itself.

According to Katherine Shear, M.D., who is lead author of a study published in the June 1 *Journal of the American Medical Association*, complicated grief shares elements of major depression (sadness, guilt, and social withdrawal) and posttraumatic stress disorder (disbelief, intrusive images, and avoidance behaviors), but treatments typically used for these disorders don't work well for people with complicated grief. Shear is a professor of psychiatry at the University of Pittsburgh and director of the Panic, Anxiety, and Traumatic Grief Program at Western Psychiatric Institute and Clinic.

In addition, since complicated grief isn't listed in the *DSM*, many clinicians may misdiagnose patients who are experiencing traumatic grief with depression, Shear added. "Helping clinicians to identify complicated grief is crucial to successful treatment."

Shear and her colleagues recruited 95 bereaved patients aged 18 to 85 through ads or professional referrals for treatment of grief from April 2001 through April 2004. To be included in the study, subjects had to meet a criterion for complicated grief, which the researchers defined as a score of 30 or more on the Inventory of Complicated Grief, a 19-item scale whose scores range from 0 to 76. The scale asks patients to rate the frequency of certain symptoms on a scale of 0 to 4, such as avoidance behaviors or feeling bitter about the person's death.

She then randomized the sample into two groups. The first group of 46 received interpersonal therapy (IPT) and the other 49 received complicated grief treatment (CGT), which Shear developed with her colleagues.

Both types of treatment were administered in 16 sessions for 19 weeks, on average.

All therapists were master's-level or doctoral-level clinicians with at least two years experience conducting psychotherapy.

IPT included discussion of how patients' symptoms related to their grief, according to the report. In addition, "the IPT therapist helped patients to arrive at a more realistic assessment of the relationship with the deceased. . .and encouraged the pursuit of satisfying relationships and activities," the authors wrote.

CGT therapists helped patients recall stories of their loved one's death while the therapist tape-recorded the patient's recollections. Periodically, the therapist would ask patients to report their levels of distress.

Patients listened to the tape between sessions. Therapists tried to reduce distress levels during each session by "promoting a sense of connection" to the loved one.

These connections included imagined conversations with the deceased and a discussion of positive and negative memories about him or her. CGT therapists also asked patients to discuss what their plans and goals would be if their grief wasn't so intense.

All patients were independently rated before and after receiving IPT or CGT using the Clinical Global Improvement (CGI) scale, which measures clinical improvement from baseline on a scale of 0 to 7.

Shear found that 51 percent of those who received CGT reported "very much improvement" (CGI score of 1) or "much improvement" (CGI score of 2) in their clinical functioning, whereas just 28 percent of those receiving IPT did.

Researchers also found that 55 percent of the CGT group experienced a 20-point improvement on the CGI compared with 25 percent of the IPT group.

Shear noted that about 45 percent of her sample was taking an antidepressant throughout the study, but that there was little difference between the two groups in the number of patients using such medication.

"These people were on antidepressant medications at the time they were recruited for the study," and it would have been unethical to ask them to stop taking the medications for the sake of the study, she noted.

"People who were on antidepressants had the same mean CGI score as those who weren't on medications," she added, "so the medications didn't seem to relieve symptoms of complicated grief."

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

An abstract of "Treatment of Complicated Grief: A Randomized Controlled Trial" is posted online at <http://jama.ama-assn.org/cgi/content/abstract/293/21/2601?>. ■

Many Young Musicians Troubled By Performance Anxiety

Performance anxiety is the bane not only of professional musicians, but of teen musicians as well. Early detection of their problem and effective treatment for it might strike a beneficial chord.

BY JOAN AREHART-TREICHEL

Performance anxiety—classified as a variant of social anxiety in *DSM-IV-TR*—is relatively common among adult professional musicians. In the largest study of the subject to date, 16 percent of some 2,000 professional musicians reported that performance anxiety was a serious problem for them.

Performance anxiety among college-age music students has also been found to be quite high—with about 21 percent to 23 percent reporting suffering from it, and about 17 reporting that it has had a negative impact on their careers.

And now a new study in press with the *Journal of Anxiety Disorders* suggests that performance anxiety is quite common among teen musicians as well. It was conducted by Lydia Fehm, Ph.D., and Katja Schmidt, Ph.D., of the Technical University of Dresden in Germany.

Fehm and Schmidt explored performance anxiety in 74 pupils attending a Dresden high school specializing in music education. In addition to pursuing a regular academic curriculum, pupils at this school attend music classes and receive instruction in playing various instruments. Most of the students have been playing musical instruments since they were about 7 years old, and nearly half made their first public debut as musicians before age 8. Most plan to continue studying music after graduating from the school.

The subjects were assessed with the German version of the Performance Anxiety Questionnaire. It contains 20 items, tapping cognitive as well as bodily symptoms of performance anxiety. The frequency of each symptom is indicated on a five-point Likert scale.

A self-rating of performance anxiety was included, along with the questionnaire as a global measure of performance anxiety. There were questions about short-term and long-term strategies that the subjects used to cope with performance anxiety and whether they believe that they needed more help in dealing with it.

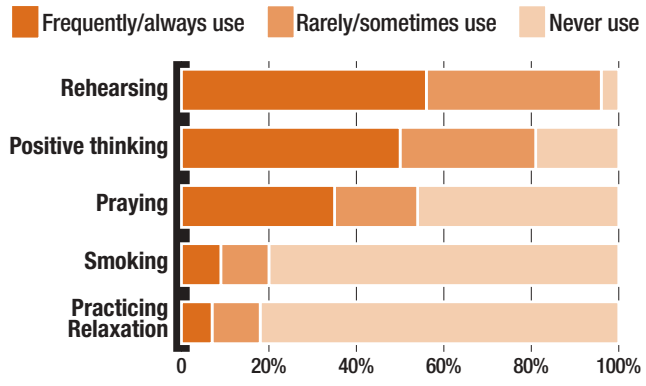
About one-third of the subjects reported being at least moderately distressed by performance anxiety. Ten percent said that performance anxiety was negatively impacting their music careers. Among the physical symptoms reported, nervousness and sweaty palms were the most frequent. Among the cognitive symptoms, fear of making errors and being overly critical of one's performance were most frequent.

The subjects indicated that they were more on edge when giving a solo performance than when playing chamber music or participating in an orchestra. Their angst also varied depending on their audience; teachers especially distressed them.

Interestingly, no link could be found between how long subjects had been performing publicly and how much they suffered from performance anxiety. "This is in line with the findings of other studies, and it points to the fact that mere exposure to public performance does not automatically lead to a decrease in anxiety," Fehm and Schmidt wrote in their report.

How Do Teen Musicians Cope?

Seventy-four students attending a German high school specializing in music education were administered the German version of the Performance Anxiety Questionnaire. Below are the most common short-term strategies that the teens reported using to cope with performance anxiety.



Source: Fehm and Schmidt, *Journal of Anxiety Disorders*, in press, 2005

Short-term coping strategies that subjects used to counter performance anxiety included rehearsing difficult parts of a composition, positive thinking, praying, smoking, and practicing relaxation techniques. Only four of the subjects said they resorted to alcohol or illegal drugs for sedation. Subjects reported that rehearsing, positive thinking, and praying were moderately helpful in quelling performance anxiety; that practicing relaxation techniques was rather helpful, but that smoking was not very beneficial.

Long-term coping strategies that subjects used to combat performance anxiety included relaxation techniques; talking with classmates, friends, or teachers about their apprehensions; and seeking professional counseling or psychotherapy. Their perceived helpfulness of these strategies was in the medium to lower range.

Sixty-seven percent of the subjects indicated that they would like more help in dealing with performance anxiety.

"We were surprised by the rather high proportion of pupils reporting impairment due to their anxiety," Fehm told *Psychiatric News*. "We would have guessed that students would become more impaired once they decide to become professionals."

"This study points to the insidious impact of the early expression of anxiety and again raises the possibility that early detection and intervention may improve the long-term course of affected individuals," Mark Pollack, M.D., added. Pollack is an associate professor of psychiatry at Harvard Medical School and director of the Center for Anxiety and Traumatic Stress Disorders at Massachusetts General Hospital.

When asked whether musicians with performance anxiety often suffer from other kinds of social anxiety as well, Fehm replied: "To my knowledge, there is no conclusive evidence regarding this issue."

An abstract of "Performance Anxiety in Gifted Adolescent Musicians" can be accessed online at <www.sciencedirect.com> by clicking on "Browse A-Z of journals," "J," and then "Journal of Anxiety Disorders." ■

Psychiatrists Often Reluctant To Encourage PADs

Advocates of psychiatric advance directives say that working with patients to draft these directives and with physicians to accept them might lead to better care and less friction between the two.

BY AARON LEVIN

Psychiatric advance directives can help patients express treatment preferences and guide physicians in moments of crisis, but both groups need more help understanding and using them, said a panel of researchers at APA's 2005 annual meeting in May.

A psychiatric advance directive (PAD) is an alternative to coercion, a document that allows competent persons to state their psychiatric treatment preferences for times when they are not competent, said Marian Butterfield, M.D., M.P.H., an associate professor of psychiatry at Duke University. The directive covers hospital admission, medication administration, use of other interventions such as electroconvulsive therapy, and may authorize a surrogate agent to act on the patient's behalf. Twenty states now have laws authorizing some form of PAD.

"A psychiatric advance directive is completed before a mental health crisis in which the patient loses the capacity to make decisions," said Butterfield. "The PAD is then consulted by treating physicians when the patient is in an impaired condition."

PADs are intended to help patients by giving them a voice in their treatment and support in times of crisis. Physicians, too, could benefit by better coordinating care with family and primary care doctors and targeting treatment more exactly, knowing what has or hasn't work in the past.

That's the theory. In practice, complications arise in creating and implementing PADs. Patients may need help in understanding their value and in filling them out. Some physicians fear that a PAD will restrict their treatment choices. Law-enforcement and hospital authorities may be unfamiliar with them and ignore them in the very times of crisis when they are intended to help.

PADs bear similarities and differences with general medical advance directives, said former APA President Paul Appelbaum, M.D., chair of the Department of Psychiatry at the University of Massachusetts and chair of APA's Council on Psychiatry and Law. Both types of documents meet with general approval by the public, but few individuals actually have them. Neither can cover every contingency, so that designating a health care proxy may be just as important. They are also often unavailable when they are most needed, and it may be hard to get officials or medical personnel to even read them, much less follow their directions, he noted.

Competency Questions May Arise

Unlike general health directives, the question of patient competence hangs over a PAD, although there is a presumption that the patient was competent when signing it.

Physicians also fear that the content of a PAD will be "crazy" and that patients will use them to refuse treatment. "In fact, patients are doing a good job of filling them out, especially if facilitators are involved," said Appelbaum.

Picking the right time to fill out a PAD is another key issue. Following passage of the federal Patient Self-Determination Act of 1990, hospitals began asking patients to complete advanced directives at admission, the worst time for any patient but especially for psychiatric patients, said Appelbaum. Completing a directive at the first outpatient visit or upon hospital discharge would be better.

PADs Can Be Empowering

A team from Duke University School of Medicine studied 1,000 outpatients in mental health clinics in Chicago, Tampa, San Francisco, Durham, N.C., and Worcester, Mass., and found that few (4 percent to 13 percent) had PADs but that 65 percent to 77 percent said they wanted one, once the idea was explained to them, said study leader Jeffrey Swanson, Ph.D., an associate professor of psychiatry at Duke. The study will be published shortly, he said.

"There's a large, latent demand," said Swanson. "The PAD gives patients some sense of empowerment at very vulnerable moments in their lives."

Patients interested in PADs tended to be female, nonwhite, suicidal, with a low sense of mastery, and a history of feeling pressured to take medications and an arrest in the prior six months, according to the Duke study.

Patients in the study who had completed a directive were more likely to have high insight (odds ratio, 1.9), a representative payee managing their money for them (3.0), been transported by the police to treatment (2.3), and feel pressure from clinicians and others to keep their appointments at community mental health clinics (1.8).

Eric Elbogen, Ph.D., an assistant professor of psychiatry at Duke, has studied 121 advanced-instruction documents produced by patients randomized from public-sector settings. The patients were assigned a bachelor's-level facilitator who helped explain their options in completing a PAD.

Most of the patients made clear the options they preferred, Elbogen noted.

For instance, 98 percent alerted doctors to at least one crisis symptom. "I want to hurt myself because the television is talking to me," said one. "I have racing thoughts and become aggressive, especially in the emergency room," wrote another. This kind of prior knowledge of violent history can help hospital staff and reduce risk when the patient appears again, said Elbogen.

Seventy-five percent of the patients said they wanted to be treated with respect and listened to if brought to the hospital. Eighty-eight percent mentioned at least one hospital to which they were willing to go, while 62 percent documented a refusal to go to a specific hospital, usually giving reasons for doing so.

Some Stated Medication Choice

PADs may help guide treatment as well. All subjects mentioned at least one factor likely to cause a relapse. Also, 77 percent rejected at least one medication, but 94 percent gave advanced consent for treatment with at least one drug. "No one refused all medications, but no one liked Haldol," said Elbogen.

Half of the patients studied instructed staff on how to avoid use of restraint and seclusion, and three-quarters listed side effects they experienced on particular medications. Sixty-two percent refused to have electroconvulsive therapy. All gave emergency contacts, usually family members.

The facilitators helped focus the documents by asking open-ended questions, Elbogen said.

"There were few medically inappropriate treatment requests in the directives, and they included much relevant information that would be valuable to clinicians," said Elbogen. The most unrealistic response was, "I need a cigarette in intake because I can't calm down without a smoke."

The authority of the PAD, however, is not absolute, said Elbogen. It does become part of the patient's chart, and if one section of the PAD can't be carried out, the rest is not invalidated. Furthermore, involuntary commitment overrides the PAD.

Clinicians have little experience with PADs so far, and they are ambivalent about them, said Marvin Swartz, M.D., professor and head of social and community psychiatry at Duke. Swartz and Elbogen are co-investigators with Swanson on the Duke study.

"About two-thirds of psychiatrists say they would honor a PAD, although many think that patients would use it to inscribe

please see ***PADs*** *on page 29*

Newer Antipsychotics Show Promise In Treating Autism Behaviors

Second-generation antipsychotics can help children with autism in a number of domains. More trials are underway to further explore the atypicals' potential for helping such youngsters.

BY JOAN AREHART-TREICHEL

Autism is characterized by impaired social interaction, abnormal language development, repetitive patterns of behavior, and serious behavioral problems such as self-injurious behavior, aggression, and tantrums.

Although second-generation antipsychotics do not seem to improve social interaction and communication in children with autism, they do appear to dampen the repetitive behavior patterns, Christopher McDougle, M.D., chair of psychiatry at Indiana University, and colleagues reported in the June *American Journal of Psychiatry* (*Psychiatric News*, June 3).

Moreover, second-generation antipsychotics appear to be capable of countering serious behavioral problems in children with autism, James McCracken, M.D., a professor of child psychiatry at the University of California at Los Angeles, and his team now report in the July issue of that journal.

In the first arm of their study, 101 children with autism received either risperidone or a placebo for eight weeks. Risperidone was found to reduce aggression, tantrums, and self-injurious behavior substantially. The researchers thus decided to see whether such improvement would endure over a longer time period.

Sixty-three subjects who responded positively to risperidone in the first trial agreed to participate in a longer one, which consisted of a 16-week open-label treatment with risperidone. Eighty-three percent were found to be much improved or very much improved as far as maladaptive behaviors were concerned.

Thirty-eight of the subjects were then enrolled in an eight-week, randomized, placebo-controlled discontinuation trial. Half of the subjects continued to receive risperidone, and half were given a placebo. Sixty-three percent of the placebo group resumed maladaptive behaviors, whereas only 13 percent of the risperidone group did—a significant difference. The return of aggression, tantrums, and agitation was five times as great in the placebo-substitution group as in the subjects who continued to take risperidone.

"Taken together, these data strongly suggest that risperidone is an efficacious treatment for short- and intermediate-term management of serious behavioral problems in children with autism," the researchers concluded.

Although the average daily dose of risperidone used in the study—about 2 mg—was relatively low, subjects gained considerable weight from it. Thus, "longer-term observations to determine the clinical significance of weight gain as well as other adverse events are needed to evaluate the risk-benefit ratio for risperidone treatment in children with autistic disorder," the investigators said.

The National Institute of Mental Health is supporting a new study to see whether combining behavior therapy with initial risperidone treatment might help prolong improvement well beyond the withdrawal of the medication. That study should be completed in about two years. "The new study could have an important impact on recommendations for the use of these medications in autism," McCracken told *Psychiatric News*.

McCracken and his group, as well as others, are conducting trials to look more closely at the cognitive effects of these drugs in children with autism. For example, might they be able to facilitate learning in some areas? Or could they impair learning in some children?

Another area they are exploring involves the provocative field of psychiatric pharmacogenomics—using patient's genes to predict medication response (*Psychiatric News*, May 20). "We have some new data that suggest that this area may be very fruitful in relation to atypical-antipsychotic effects in children with autism," said McCracken.

The study was financed by the National Institutes of Health and the Korczak Foundation.

"Risperidone Treatment of Autistic Disorder: Longer-Term Benefits and Blinded Discontinuation After Six Months" is posted online at <http://ajp.psychiatryonline.org/cgi/content/full/162/7/1361>. ■

JANSSEN RISPERDAL
P4C

Psychiatric Illness May Affect Data on 'Healthy' Subjects

Some people who volunteer to be "healthy" controls in psychiatric or other medical research may have personality disorders. Most such volunteers, however, are not screened for Axis II disorders before the study begins.

BY JOAN AREHART-TREICHEL

One of the hallmarks of medical research, including psychiatric studies, is the use of "healthy control" subjects against which a population of interest is compared.

Yet it looks as though a large number of persons who volunteer to serve as control subjects have personality disorders, a new study suggests.

The study was conducted by Emil Coccaro, M.D., chair of psychiatry at the University of Chicago, and colleagues. Results appear in the July *Journal of Psychiatric Research*.

Some 340 individuals who answered a newspaper ad looking for people to participate "in a medical research study of hormone response" and to be paid for it were the focus of the study. Coccaro and his coworkers used structured clinical interviews—the Structured Clinical Interview for *DSM* Diagnoses and the Structured Interview for the Diagnosis of *DSM* Personality Disorder (SIDP)—to determine whether any of the volunteers currently had or had a history of any psychiatric disorders, and if so, which ones.

They found that 45 percent of these volunteers had a lifetime history of one or more Axis I disorders and that 48 percent of these volunteers had a personality disorder.

Moreover, the most frequent personality disorder diagnosis was personality disorder not otherwise specified (25 percent of those with a personality disorder), followed by obsessive-compulsive disorder (7 percent), narcissistic personality disorder (6 percent), and paranoid personality disorder (almost 6 percent).

Furthermore, volunteers with personality disorders were found to differ from volunteers without such disorders in clinically significant ways. For example, they tended to exhibit more impulsivity, affective lability, trait anxiety, hostility, and aggression than the latter group did.

These findings have important implications, the researchers believe. For example, with regard to Axis I disorders, the lifetime history of psychiatric disorders found in these subjects is quite close to the 48 percent found in studies of the general American population. Thus the subjects may well represent the general population on this comparison. However, while 48 percent of the subjects were found to have a personality disorder, only 15 percent of the general American population meets criteria for such a diagnosis (*Psychiatric News*, September 3, 2004).

And even if such individuals were a true random sample of Americans, investigators would probably not want to use them as "healthy controls" since there is reason to believe that some of the characteristics they possess could bias study outcomes, Cocarro and his coworkers indicated in their report. For instance, studies have shown that trait anxiety can influence hypertension, and impulsiveness can alter neurotransmitter activity.

The problem, Cocarro and his team concluded, is that while most scientists screen potential control subjects for Axis I disorders (at least in psychiatric research), they do not screen them for Axis II disorders. Hence individuals with personality disorders can easily be enrolled to serve as controls and thus may bias research outcomes.

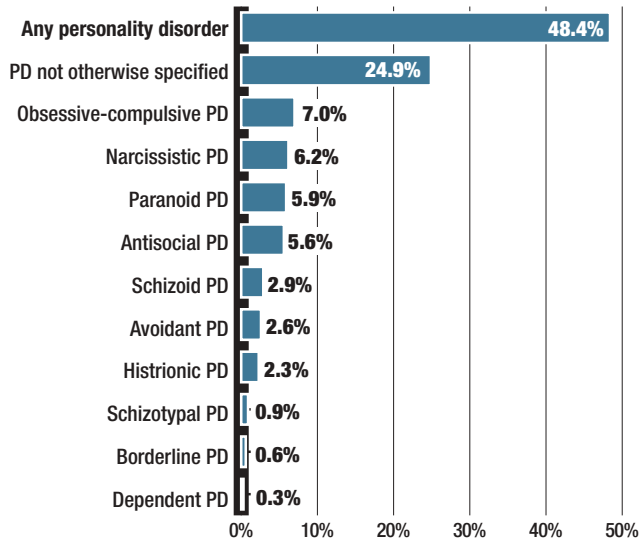
"Two methodologic issues may compromise these data to some extent," Paul Appelbaum, M.D., told *Psychiatric News*. In addition to being chair of psychiatry at the University of Massachusetts and a former APA president, Appelbaum has written extensively on the use of mentally ill subjects in research studies.

"First, these subjects were recruited from a newspaper ad that began by stressing the money that was being offered rather than, for example, the opportunity to contribute to advancing knowledge of hormone responses. . . .Thus, the findings of a high prevalence of personality disorders in the resulting group of volunteers may be specific to the means used here to recruit them. Focus on a desire for money when you recruit subjects, and you may get what you pay for. Second, the accuracy of the data is entirely dependent on the validity of the diagnostic method used. Structured instruments like the SIDP are known to overestimate—sometimes markedly—the rate of

please see ***Subjects*** *on page 29*

Personality Disorders Common

Researchers who recruited 340 volunteers through a newspaper ad to participate in a "medical research study" found that almost half of the subjects had some kind of personality disorder.



Source: S.C. Bunce et al., *Journal of Psychiatric Research*, July 2005

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med check

COMPILED BY JIM ROSACK

This is the second of a Med Check series featuring new research presented at APA's 158th Annual Meeting, held May 21 to 26 in Atlanta. New research presentations are generally preliminary in nature and involve research that has yet to be peer reviewed for publication. Reports may involve the use of medications for purposes that the Food and Drug Administration has not approved and are largely funded by product manufacturers.

This Med Check features new research reports on the use of medications to treat attention-deficit/hyperactivity disorder and bipolar disorder. New research reports on pharmacotherapy targeting depression/anxiety, psychotic disorders, and substance use disorders will be presented in subsequent columns.

Attention-Deficit/Hyperactivity Disorder (ADHD)

• ***Atomoxetine*** significantly reduces core symptoms in children with ADHD for as long as 24 hours compared with placebo, reported Humberto Quintana, M.D., of Louisiana State University, and colleagues. In a secondary analysis, the team found some differences in the drug's effects when given once daily in the morning compared with once daily in the evening.

The results are from a randomized, double-blind, placebo-controlled trial that involved 288 children with ADHD. The six-week study compared a group who took atomoxetine in the morning with a group who took the drug in the evening, and compared both groups with a placebo-control group. Children in both drug-dosing schedules did statistically significantly better than those on placebo.

The group on the morning dose did better than the group on the evening dose as measured by the ADHD Rating Scale, the hyperactive/impulsive subscale of the ADHD-RS, and on Clinical Global Impression–Severity Scale. In addition, the children on the evening dose were more likely to experience an adverse event than the children on the morning dose. However, no differences were seen in the two groups in terms of the children's behavior in the morning and in the evening as assessed by their parents. Further, both groups displayed clinically significant improvement 24 hours after receiving a dose.

The most common adverse events noted in those taking atomoxetine were abdominal pain, decreased appetite, vomiting, headache, somnolence, and nausea.

APA 2005: NR 467 & NR 469; Funding: Eli Lilly and Co.

• ***Modafinil,*** in a once-daily pediatric formulation, was found to be both safe and effective in children with ADHD aged 6 to 17 in terms of improving behavior and lessening the severity of symptoms associated with ADHD, reported Laurence Greenhill, M.D., of the New York State Psychiatric Institute, and colleagues.

For the nine-week study, 163 patients were randomly assigned to either modafinil or placebo. Modafinil was associated with robust improvement (effect size 0.69) in ADHD symptoms measured on the ADHD Rating Scale, the Connors' Parent-Rating Scale, and the clinician-rated Clinical Global Impression–Improvement (CGI-I) subscale. Modafinil was associated with significant improvements in overall condition (CGI-I score of 1 or 2) in 48 percent of patients, compared with 17 percent for those taking placebo.

The most common adverse events in patients taking modafinil were insomnia (29 percent compared with 4 percent in placebo), headache (20 percent vs. 15 percent), and decreased appetite (16 percent vs. 4 percent). Similar results were reported by James Swanson, M.D., of the University of California-Irvine, and colleagues, in a trial using the same protocol involving 128 patients. Effect size in the second study was 0.64 for modafinil.

APA 2005: Scientific & Clinical Report Session 4, No. 13, and Session 16, No.47; Funding: Cephalon

Bipolar Disorder

• ***Intramuscular aripiprazole*** appears to be as effective as lorazepam at reducing agitation in patients with bipolar I disorder with either mixed or manic episodes, reported Dan Oren, M.D., of Bristol-Myers Squibb Co. and colleagues at BMS and Otsuka Pharmaceuticals. In a randomized, double-blind trial, 301 voluntarily hospitalized patients with acute agitation associated with bipolar disorder were administered either placebo, 10 mg IM aripiprazole, 15 mg IM aripiprazole, or 2 mg IM lorazepam.

Two hours after injection, patients who received 10 mg aripiprazole saw a mean improvement of 8.7 points on the Positive and Negative Syndrome Scale–Excited Component, compared with 8.7 points for those receiving 15 mg aripiprazole, 9.6 points for those receiving 2 mg lorazepam, and 5.8 points for those receiving placebo.

At two hours, 37 percent of those on placebo were classified as responders (CGI-I score of 1 or 2) compared with 69 percent of those receiving 10 mg aripiprazole, 63 per-

please see ***MedCheck*** *on page 30*

Medication Names and Manufacturers

The following medications appear in this edition of Med Check:

- **Aripiprazole:** Abilify (Bristol-Myers Squibb)
- **Atomoxetine:** Strattera (Lilly)
- **Lamotrigine:** Lamictal (GSK)
- **Lorazepame:** Ativan (Wyeth); generics
- **Modafinil:** Provigil (Cephalon)
- **Olanzapine:** Zyprexa (Lilly)
- **Olanzapine/fluoxetine combination:** Sumbyax (Lillye)
- **Quetiaipine:** Seroquel (AstraZeneca)
- **Risperidone:** Risperdal (Janssen)

In San Diego, Fine Dining Doesn't Mean High Cost

The San Diego area can satisfy the most demanding palate in every price range and many traditions.

BY RODRIGO MUÑOZ, M.D.

Some of us can't believe that APA's 2005 Institute on Psychiatric Services is our 57th. Community psychiatry has come of age, and we are enjoying our performance. Community psychiatrists share a lot in many ways, such as support of community efforts, interest in new ideas for better clinics in poor areas, casual clothing, and, of course, casual eating. While I intended to write only about high-end restaurants in this article, my resolve didn't last long. I grew up on rice and beans and still relish going to places where I can enjoy a simple but delicious meal.

Expensive restaurants in San Diego are keeping up with expensive restaurants elsewhere. Not being used to them, I usually avoid them. To the contrary, places that offer sound, decent, reliable food are close to my heart. Take the case of Chuy's in National City. It was there for migrant neighbors when they couldn't pay, and it is still there today, offering the same carnitas, tacos, enchiladas, and tamales to a more prosperous but equally selective clientele. I want to invite you there. Next door is Family Health Centers, the clinic for Latinos where I have been involved for almost 30 years. Come and see a center run, staffed, and enhanced without control by the local government. (Viva la Raza!)

San Diego Convention and Visitors Bureau

Many San Diego–area restaurants serve up beautiful waterside views along with their carefully prepared dishes.

Our very special import from Georgia, Jimmy Carter (no relation, but same politics), runs the community center, political forum, and best restaurant in my neighborhood downtown. For a while we had Howard Dean campaign meetings there every Wednesday. Jimmy offers typical American, Indian, Chinese, and, of course, Mexican fare. My Latin friends, my friends from elsewhere (Harold Eist), and my patients have declared that Jimmy's carne asada is the best on the planet. My discriminating friends encourage me to ask for the Indian dishes, which I consider superb.

I highly recommend the Prado. It has the best cuisine of many of the high-end restaurants and a distinctive international character (try the international drinks). The restaurant is located in the House of Hospitality, a classic example of the Spanish Colonial Revival–style buildings constructed for the 1915 Panama-California Exposition. Wrote one restaurant reviewer about Prado, "Yes, a restaurant can have brains as well as beauty." You can come with a few friends at minimal cost by taxi and open yourself to all the amenities of Balboa Park, ending with one of the best dinners in town. Balboa Park is the home of more than 85 performing arts and international cultural organizations, 15 museums, the San Diego Zoo, and extensive gardens painstakingly maintained.

San Diego has been enriched by the industrious Thai and Vietnamese cuisine masters who have come to our city determined to succeed. Many of their restaurants are very good and not expensive. My favorite is A Taste of Thai. The delicacy of Eastern cooking and the excellent quality of the basic products used in its dishes work together to satisfy the taste of even the most demanding Californians.

California is a melting pot, and unusual events occur in the pot. Take the case of the Mexican chef who comes to California, works at a Mediterranean restaurant, and produces incredible Mexican-Mediterranean dishes. That's the case at Candelas.

Perhaps you want a completely different experience. If you want to drive north to be in communion with the ocean while enjoying your dinner, just take Highway 5 to Solana Beach, go to the venerable Highway 101, continue north, and soon you will see the Chart House and the Poseidon a few inches from the ocean. If you decide that you would rather *see* than *feel* the ocean, come back to Del Mar and be dazzled by ocean as far as you can see while enjoying the wonderful hospitality and good food of Pacifica Del Mar.

I have been at Jake's in Chula Vista and Del Mar. Jake's is a charming waterfront restaurant specializing in fresh seafood. I appreciate the restaurant's attention to quality, good service, and great vistas, along with its open space and elegance. ■

Rodrigo Muñoz, M.D., is a local arrangements consultant for the 2005 Institute on Psychiatric Services and a past president of APA.

Plan Ahead

A Taste of Thai
527 University Avenue, San Diego
(619) 291-7525

Café Pacifica
2414 San Diego Avenue, San Diego
(619) 291-6666

Candelas Restaurant
416 3rd Avenue, San Diego
(619) 702-4455

Chart House
2588 South Highway 101, Encinitas
(760) 436-4044

Chuy's
1894 Main Street, San Diego
(619) 234-6937

Jake's San Diego Bay
570 Marina Parkway, Chula Vista
(619) 476-0400

Jimmy Carter's Cafe
3172 5th Avenue, San Diego
(619) 295-2070

Pacifica Del Mar
1555 Camino Del Mar, Del Mar
(858) 792-0476

Poseidon Restaurant
1670 Coast Boulevard, Del Mar
(858) 755-9345

The Prado
1549 El Prado, San Diego
(619) 557- 9441

More information on restaurants in the San Diego area is posted online at <www.sandiegorestaurants.com/> and <www.sandiego.org/dining/index.asp>. Online reservations may be made for many San Diego restaurants at <www.sandiegorestaurants.com>.

Register Now!

A copy of the preliminary program booklet, which includes registration, housing, and air travel information, can be obtained by calling (888) 357-7924 or by clicking on the IPS logo on APA's Web site at <www.psych.org>.

Register in one of three ways:

- Register online by going to the Web site <www.psych.org/edu/ann_mtgs/ips/05/index.cfm> and click on "Registration Form."
- Download a registration form from the above site and mail or fax the completed form to APA.
- Use the registration form found in the preliminary program booklet and mail or fax the completed form to APA.

Register before September 6 and save on fees. A discounted fee is available for residents; medical students attend free.

Forum Will Help Psychiatrists Explain Medicare Part D

Psychiatrists will learn the nuts and bolts of the new Medicare Part D drug benefit so that they can help their patients select the plan that best fits their needs.

BY ELLEN JAFFE

A forum that will provide APA members with the practical information they need to help their patients navigate Medicare's new Part D pharmaceutical benefit has been added to the schedule of APA's 2005 Institute on Psychiatric Services.

The institute will be held in San Diego from October 5 to 9 (see above box for registration information).

The forum, "Readying for the New Medicare Pharmacy Benefit: The Part D Challenge," will be sponsored by APA's Office of Healthcare Systems and Financing and chaired by Director Irvin "Sam" Muszynski. It is part of APA's ongoing effort to educate members about Medicare's new prescription drug benefit, which begins on January 1, 2006.

The forum will be held on Friday, October 7, at 10 a.m.

Said Muszynski, "Deciding which Part D pharmacy plan to participate in will be a daunting task for almost all Medicare beneficiaries, but especially for dual-eligible beneficiaries, whose drug benefit will be transferred from their state's Medicaid program to Medicare. We anticipate that patients will be very dependent on their physicians to help them make the right decision.

"Although the implementation timeline of Part D is in place, the details are still being worked out by the Centers for Medicare and Medicaid Services. We're hoping that by October 7 we'll have more hard information to provide to IPS attendees."

Part D will be administered by commercial prescription drug plans (PDPs). Beneficiaries will be able to select the plan that they believe best meets their needs beginning on November 15.

Starting in late October, dual-eligible beneficiaries will be enrolled automatically in one of the PDPs in their region with the lowest premiums. Although they have the right to switch to another plan with an equivalent premium prior to January 1, 2006, their ability to do so greatly concerns patient advocates, given the amount and complexity of information that must be considered in selecting a plan. ■

Ellen Jaffe is the Medicare specialist in APA's Office of Healthcare Systems and Financing.

57th Institute on Psychiatric Services
APA's Leading Educational Conference on Public and Community Psychiatry

AMA

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tion Council on Psychiatry and were approved virtually without opposition (see story on page 8), the council's report on SSRIs is evidence of the growing influence of psychiatry within the house of medicine, APA leaders say.

"This is an excellent example of the importance of psychiatry's involvement in the house of medicine," said John McIntyre, M.D., chair of the Section Council on Psychiatry and head of APA's delegation. "This issue was identified by APA and AACAP last year, and as the report was being prepared, there was dialogue between the AMA and APA around the content of the report.

"This is a major issue for our patients," he added. "We are now at a level of participation that when issues come up that involve our patients, we can be confident that we will be part of the solution."

David Fassler, M.D., vice chair of the Section Council on Psychiatry and AACAP's delegate, was the author of the original resolution calling for the report. He said during reference committee hearings that the report would likely do much to dispel public and professional confusion that has surrounded the FDA's action regarding antidepressants and children.

"The conclusions and recommendations. . . confirm that medication can be an effective and important component of treatment for children and adolescents with depression," Fassler said. "The report also acknowledges the importance of continued access to the full range of these medications, and it calls for ongoing research with an emphasis on larger studies and long-term follow-up, which will ultimately give us more clinically relevant data regarding both the safety and efficacy of these medications."

(Reference committee hearings are held prior to the convening of the House of Delegates and offer an opportunity for any AMA member and invited public representatives to voice opinions on all reports and resolutions brought to the House. On the basis of testimony heard at the reference committee, a recommendation is made to the full house to adopt, amend, or not adopt those reports and resolutions; a decision is also sometimes made to refer an item for deliberation to the AMA Board of Trustees or to an appropriate council.)

Melvyn Sterling, M.D., an internist and chair of the CSA, urged adoption of the report during reference committee hearings, saying the issue was one of the most important facing physicians who treat children and adolescents.

"As director of an emergency department of a university medical center, I have treated thousands" of people who have made suicide attempts, Sterling said. "I view this as one of the most important conditions that we as physicians and a society have to deal with. We have to deal with suicidality and with the awesome social and economic impact of depression on our society. For us to deny patients access to what could be the most important medication in their lives, when the data [about suicide] are actually equivocal, I think would be very, very sad."

The CSA report summarizes recent regulatory actions related to the labeling of antidepressants and their use in children and adolescents; evaluates the apparent safety and efficacy of antidepressants, particularly the SSRIs in children and adolescents; and reviews the evidence on whether these drugs may have a causal role in the emergence of suicidality or other harmful behavior during treatment.

The report concludes with four recommendations:

- That SSRIs should remain available for use in children and adolescents, including unlabeled uses, subject to the exercise of prudent clinical judgment and development of clinical guidelines for treatment. Current clinical evidence indicates that fluoxetine is an effective SSRI in children and adolescents with major depressive disorder, the report states.
- That the AMA urge the Food and Drug Administration (FDA) to ensure that studies conducted by sponsors in pursuit of pediatric exclusivity be adequately designed and of sufficient duration to answer clinically relevant efficacy and/or safety questions that have evolved in a particular therapeutic area.
- That the AMA recognize that the current product labeling (package insert) of antidepressant drugs, including the black-box warnings, is a precautionary statement intended to reinforce the need for careful monitoring of patients with depression and other psychiatric disorders during the initiation of treatment. This product labeling should not be interpreted in a way that would decrease access for patients who may benefit from these drugs, the report states.
- That the FDA evaluate the impact of labeling changes it mandates for antidepressants, including the black-box warnings and patient medication guide on treatment patterns, patient compliance, and patient access.

In related action, the House of Delegates adopted, without debate, a second resolution put forward by APA and AACAP that asks the AMA to endorse efforts to train additional qualified clinical investigators in pediatrics, child psychiatry, and therapeutics to conduct studies related to the effects of psychotropic drugs in children, adolescents, and young adults.

That resolution also asks the AMA to promote efforts to educate physicians about the appropriate use of psychotropic medications for children, adolescents, and young adults.

More information about these and other actions taken at the AMA's 2005 annual meeting are posted online at <www.ama-assn.org/ama/pub/category/14887.html>. ■

clinical & research news

Subjects

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personality disorders in a sample."

Yet assuming that the findings are valid, Appelbaum said, "they do suggest reason for caution in recruiting and screening subjects. . . .The authors suggest more intensive screening for personality disorders, but there are other solutions too. It may well be worth experimenting with the recruitment message, for example, stressing altruism versus self-interested motives, to see the effect on who volunteers. Or more epidemiologically valid methods of recruiting samples from the general population might be employed, rather than relying on newspaper ads."

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

An abstract of "High Prevalence of Personality Disorders Among Healthy Volunteers for Research: Implications for Control-Group Bias" can be accessed online at <www.sciencedirect.com> by clicking on "Browse A to Z of journals," then "J," then "The Journal of Psychiatric Research." ■

PADs

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treatment refusal," he said, drawing from his random sample of psychiatrists in North Carolina, where PADs have been authorized since 1997.

Responses from the psychiatrists surveyed varied depending on hypothetical circumstances, said Swartz. Asked if they would follow a PAD if a patient were concerned about drug side effects, 70 percent of the doctors said yes. But if the PAD as written sounded "psychotic," and the patient had a history of violence, only 40 percent said they were likely to follow it. Public-sector psychiatrists were less positive about PADs and more certain that they would have no impact on their practice.

In the end, the value of a PAD may lie as much in its role as a form of communication with future clinicians as in the fact that it is a legally binding document, said Appelbaum. A purely informational system does exist in the United Kingdom, he said, where "crisis cards" serve as nonbinding directives, telling clinicians in effect: "If I get in trouble, here's what helps me. . . ."

Information about psychiatric advance directives is posted online at <http://ps.psychiatryonline.org/cgi/content/full/56/5/592?> and <http://ps.psychiatryonline.org/cgi/content/full/55/7/751>. ■

professional news

Genomics

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knowledge of individual genomic variation to prevent and cure major mental disorders, rather than merely manage and treat them.

"The endgame is individualized care," Insel said. "It is not hard to imagine a time when you would know which person was at very high risk for schizophrenia, and you would have the neuroimaging data you would need to watch a patient very carefully. At age 16 when the patient begins to develop a sleep disturbance and ideas that are even stranger than those of his peers, you would know that this was a patient with whom you would want to intervene."

He asked, "Why aren't we thinking about preventing the first break and putting together the kind of science that we need to do that?"

Information about the International HapMap Project is posted online at <www.hapmap.org/>. ■

letters to the editor

More Frequent *DSM* Updates Recommended

There should be a new edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* each year. The present *DSM* has diagnostic criteria last updated in the early 1990s, with text last updated in the late 1990s. The clinician turning today to the *DSM-IV-TR* does not know whether the conceptualization of the criteria over the past dozen years has changed and does not know the currency of the text. Examples of the need for diagnostic criteria classification are in the areas of childhood bipolar disorder and adult attention-deficit/hyperactivity disorder, where *DSM-IV-TR* is unenlightening. In addition, disorders have emerged and grown, such as fetal alcohol syndrome, on which the *DSM-IV-TR* is silent.

Some say that the costs of such an endeavor would be astronomical and that to develop each new criterion set would be a million-dollar project. That is not true. APA can and should do what other medical specialties do: have the experts state where the field is today—not require the development of new science.

Some say that publishing a new *DSM* each year would be seen as a revenue-driven initiative. That is not true. Each year the specific changes could be placed on the APA Web site for those not wanting to buy the book.

APA does not plan to complete a substantial revision of the *DSM* until about 2012. We should not assume that the growth of knowledge in psychiatry is so minimal that we are justified in waiting until then.

ROGER PEELE, M.D.
Rockville, Md.

MARYAM RAZAVI, M.D.
Washington, D.C.

Darrel Regier, M.D., M.P.H., responds. He is director of APA's Division of Research and executive director of the American Psychiatric Institute for Research and Education.

The possibility of developing a process for more frequent updates of the *DSM* has been discussed with APA's Committee on Psychiatric Diagnosis and Assessment and the Board of Trustees on several occasions over the past two to three years. Models for such updates are the AMA's CPT procedure codes, APA's practice guidelines, and the National Center for Health Statistics' *ICD-9-CM* annual updates of diagnostic codes. These organizations and agencies have established a permanent infrastructure to support regular reviews of emerging medical procedures, the clinical trials and other research bases to support treatment modifications, and proposals from the scientific community for changes in diagnostic names or code numbers. However, modifications of explicit diagnostic criteria in the *DSM-III*, *DSM-III-R*, *DSM-IV*, and *DSM-IV-TR* have not been made between revisions because of the absence of a credible, established scientific review structure and because of a concern that each change could have significant impacts on national and international research studies, which include the clinical trials that lend support for treatment guidelines.

The Division of Research is currently reviewing the research base for modifying diagnostic concepts and criteria in *DSM-V* with a $1.2 million grant from the National Institutes of Health. At the same time, we are examining alternatives both for modifying the text more frequently to reflect new associated features and for considering changes in the criteria for individual disorders when substantial scientific evidence supports such changes. ■

Readers are invited to submit letters not more than 500 words long for possible publication. *Psychiatric News* reserves the right to edit letters and to publish them in all editions, print, electronic, or other media. Receipt of letters is not acknowledged. Letters should be sent by mail to *Psychiatric News,* APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209 or by e-mail to pnews@psych.org. Clinical opinions are not peer reviewed and thus should be independently verified.

Medicare

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FAQ in the section headed "Note (Attachment I)." One of the five exceptions listed is of particular interest to the mental health community. The note states that "all formularies must include either escitalopram [Lexapro] or citalopram [Celexa]."

CMS states that the list of exceptions should not be viewed as a list of exclusions and that each PDP's Pharmacy and Therapeutics Committee will have the final say on whether the plan covers only escitalopram or citalopram, or both.

Choice Sparks Concern

In the FAQ document posted on June 15, CMS did not explain why formularies are directed to include escitalopram or citalopram, but not both. However, a version of the FAQ posted on June 10 stated, "Either escitalopram or citalopram may be left off formularies since escitalopram is the component of citalopram that is responsible for the antidepressant effect."

Pharmacologically, the agency is correct about escitalopram's antidepressant effect. Escitalopram, which was developed by Forest Laboratories as a successor to citalopram, contains half of the active ingredient found in the older product. The active ingredient occurs as nearly identical chemical isomers, which exist as mirror images of one another. Escitalopram—designated chemically as "S-citalopram"—is the half thought to be responsible for the medication's antidepressant effect. However, citalopram is roughly half S-citalopram and half R-citalopram. The R-isomer, which does not have antidepressant effects, is thought to interfere somewhat with the S-isomer's beneficial effects. In addition, the R-isomer is thought to be responsible for many of the adverse effects of citalopram. By eliminating the R-isomer from the parent compound, Forest aimed to produce a better tolerated and more effective antidepressant.

Coalition Still Concerned

After reviewing the FAQ posted on June 10, mental health advocacy organizations, including APA, the National Alliance for the Mentally Ill, the National Mental Health Association, and the Treatment Effectiveness Now Project, brought their concerns to CMS. They fear that PDPs will choose to cover the less-expensive generic citalopram over escitalopram, which is available only as the Lexapro brand, despite the fact that the two drugs are not interchangeable, pharmacologically or therapeutically.

The final FAQ eliminated the suggestion that the two drugs are therapeutically interchangeable and noted that all formularies had to include only one.

Overall, the policy as stated in the FAQ appears to ensure broad access to nearly all psychotropic medications through the PDPs approved by CMS to participate in Medicare Part D, noted Irvin L. "Sam" Muszynski, J.D., director of APA's Office of Healthcare Systems and Financing. The policy also appears to protect patients who are now covered under Medicaid and will transition to Part D on January 1, 2006, by ensuring that their existing medications will continue to be covered—even escitalopram.

Muszynski added, however, that it remains to be seen whether patients who are prescribed escitalopram for the first time after January 1, 2006, will be able to get it through their PDP.

"The policy expressed in the CMS guidance and clarified in the FAQ document clearly represents a major step forward in ensuring continuity of care for dual-eligible patients transitioning to the new benefit," Muszynski said. "The policy generally reaffirms the position APA and our partners. . . have been strongly advocating from the beginning: that [individual medications within the antidepressant and antipsychotic classes] are not therapeutically interchangeable. We remain concerned, however, about how to interpret certain parts of the guidance [that] continue to appear problematic."

Muszynski and the staff in APA's Division of Advocacy are continuing to monitor and analyze CMS's developing policies regarding the implementation of Part D.

The CMS FAQ document can be accessed online at <http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php> by searching on the word "antidepressants." ■

government news

Governors

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(W.Va.), blamed the impact of federal and state tax cuts for the depletion of revenue needed for Medicaid, according to the Web site <www.kaisernetwork.org> on June 16.

Lizbet Boroughs, deputy director of government relations in APA's Department of Government Relations (DGR), said that DGR agreed with Families USA's assessment that the NGA proposal is a mixed bag.

"We remain concerned with the NGA's emphasis on closed formularies but are somewhat heartened by its discussion of medically fragile populations and improving care coordination since many adults with severe and persistent mental illness may benefit from such coordination," she commented.

In related news, Sen. Gordon Smith (R-Ore.) declined an invitation from Senate Majority Leader Bill Frist (R-Tenn.) to participate in a commission established by Michael Leavitt, secretary of Health and Human Services, to make recommendations about ways to reduce Medicaid spending.

Smith spearheaded the effort to establish a commission to study Medicaid before making program cuts. Democratic legislators had already refused to participate in the commission after Leavitt announced that he would appoint the 15 voting members and that the eight members of Congress on the commission would serve only in nonvoting advisory positions.

"Medicaid Reform: A Preliminary Report" and related Congressional testimony are posted at <www.nga.org>. ■

med check

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cent of those receiving 15 mg aripiprazole, and 69 percent in those receiving lorazepam.

The most common adverse events seen with aripiprazole were nausea, headache, dizziness, and somnolence. The most common adverse events seen with lorazepam were sedation, dizziness, and somnolence.

APA 2005: NR 275; Funding: BMS/Otsuka

• ***Lamotrigine*** alone may be as effective as lamotrigine combined with other psychotropics in stabilizing patients with bipolar disorder who are in a depressive episode, reported Beth Bentley, Pharm.D., of GlaxoSmithKline.

Data from two eight- to 16-week open-label phases of two long-term lamotrigine maintenance trials were combined. Of the 1,305 patients in the combined trials, 897 had depressive symptoms.

In the first study, 161 patients received lamotrigine as monotherapy. In the second study, 736 patients received lamotrigine plus other psychiatric medications (most commonly antidepressants). Compared with patients who received lamotrigine as adjunctive therapy, patients who entered the clinical trial on no medication and received only lamotrigine experienced statistically significantly greater rates of stabilization and improvement in scores on the Hamilton Rating Scale for Depression. In addition, none of the monotherapy patients exhibited signs of switching to mania.

APA 2005: NR 306; Funding: GSK

• ***Olanzapine/fluoxetine combination (OFC)*** produced significantly greater improvement in patients with bipolar depression in overall severity of illness, depressive symptoms, and manic symptoms compared with lamotrigine therapy in patients with bipolar depression, reported Paul Keck Jr., M.D., of the University of Cincinnati and colleagues at Eli Lilly.

During the acute phase of a randomized, double-blind comparator study, 410 patients were randomly assigned to either OFC or lamotrigine. The OFC group saw greater improvement on average across the seven-week acute phase of the study (as measured by Clinical Global Impression–Severity scores). In addition, the OFC group had greater improvement on the Montgomery-Asberg Depression Rating Scale, Global Assessment of Function Scale, and Clinical Global Impressions–Improvement Scale.

Significantly more patients treated with OFC reported somnolence, increased appetite, dry mouth, sedation, weight gain, and tremor. Those taking lamotrigine reported significantly higher rates of serious adverse events, such as rash.

APA 2005: NR 376; Funding: Eli Lilly

• ***Olanzapine, quetiapine, and risperidone*** are not significantly different from one another with respect to patients' self-reported levels of function and overall measures of health-related quality of life, reported Krishnan Ramaswamy, Ph.D., of Janssen Medical Affairs and colleagues.

The researchers used the Short Form-8 Health Survey to measure mental and physical health status, including a wide array of adverse effects, and the Psychological General Well-Being Scale to measure patient functioning. There were 240 subjects (81 taking olanzapine, 95 quetiapine, and 64 risperidone).

Patients taking any of the three experienced sedation and decreased libido at varying rates; however, the differences were not statistically significant. Only two adverse events, insomnia and concentration difficulties, were statistically significantly different between the three drugs. There were no statistically significant differences in overall quality of life or functioning between the three groups of patients.

APA 2005: NR 394; Funding: Janssen Medical Affairs ■

community news

Obstacles

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accommodations can be made for Education Plus students, she added.

"I've seen students' self-esteem improve a great deal" since starting with Education Plus, Centanni said.

Students in the program have met requirements for honor roll and the dean's list, she noted. After graduating, some have become emergency medical technicians, insurance agents, and personal trainers, for instance.

Students Benefit From Social Support

Some students may have trouble forming friendships on campus or feel as though they can't fit in with their classmates, Centanni said.

They and others are encouraged to attend a peer support group for Education Plus students held each week during the school year. "It's not a therapy group," Centanni emphasized, but "a place where students can meet others who face similar difficulties. . . . It's also a friendship network."

The majority of Education Plus students are in their late 20s, but the age range is wide.

Since the program began 2002, more than 60 students have received supported-education services, and about 30 are currently participating.

Most are seeking associate degrees from the Community College of Philadelphia. Other students have enrolled at Temple University, Drexel University, DeVry University, LaSalle University, and career institutes in the Philadelphia area.

Solomon described supported education as a "burgeoning" field and said she knew of only about 30 across the country. "It was once thought that people with mental illness were incapable of holding down a job," a notion that proved incorrect with the advent of supported-employment programs. "Supported education is the next step," she said.

Mark Selzer, Ph.D., who helped develop Education Plus with Solomon, said he believes that supported-education programs are essential to professional advancement for those with serious mental illness.

Selzer is director of the UPenn Collaborative on Community Integration, which promotes community integration for people with mental illness, and an assistant professor of psychiatry at the University of Pennsylvania School of Medicine.

"Instead of viewing mental illness as the primary source" of problems with job attainment and/or career advancement, he said, "we need to look at other things that may hamper professional success."

Selzer noted that research has demonstrated that people with serious mental illness have lower educational levels than the general population, and "we know that education is probably the number-one factor in obtaining employment for anyone."

"A good number of people with serious mental illness do have the ability to return to college and reach their educational goals with the right supports," he said.

Information about Horizon House and its programs is posted online at <www.hhinc.org>. ■

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